

STORAGE

THE PRACTITIONERS' MONTHLY.

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PUERPERAL .. SEPSIS ..

J. Clifton Edgar, M. D., recently read a paper of especial value before the New York Academy of Medicine, which illustrates the need of prophylactic measures in these cases. He said that "Endometritis was the most common lesion in cases of puerperal sepsis and named two principal varieties, septic and putrid. He showed that frequently the process started from a vaginitis. With regard to prophylaxis, the speaker urged the necessity of great personal cleanliness on the part of both physician and nurse, with special precaution on the limitation of internal examination. With proper asepsis before, during and after parturition the danger of Endometritis is unminimized." In this connection we would mention the value of Glyco-Thymoline for irrigation purposes in these cases. This preparation, while strongly antiseptic, is non-toxic, and non-irritating and its action is to deplete inflammatory engorgements by rapid exosmosis, drawing outwardly through the capillaries the products of inflammation. This action checks re-absorption of ptomaines and produces a degree of asepsis that is unsuitable for the further propagation of pathogenic bacteria. Bearing on this subject, T. R. Maxfield, of Brooklyn, N. Y., states:

"Have been using Glyco-Thymoline for years. For the past two years my favorite use for it has been in obstetrical work. I never go to a case without a two-ounce bottle of it in my grip, although I usually order it in advance for general washing. I have formed the practice of giving an intra-uterine douche of Glyco-Thymoline in each case. This thoroughly cleanses the organ of membrane, fragments of placenta, etc., and reduces all danger of infection to a minimum. Hemorrhages (secondary) or fever are almost out of the question."



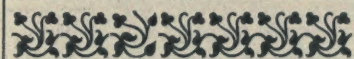
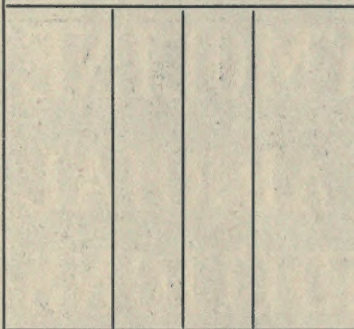
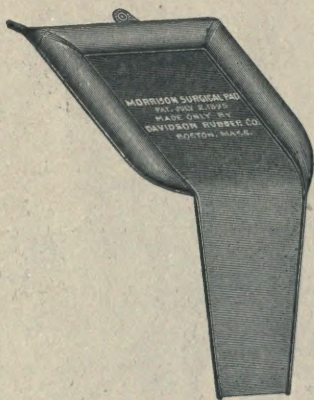
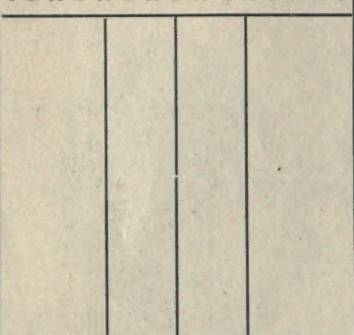
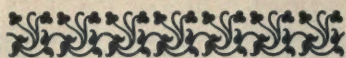
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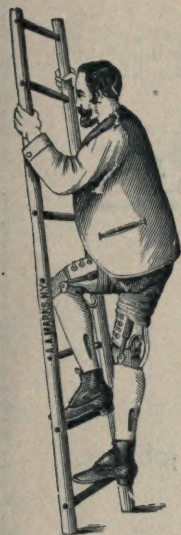
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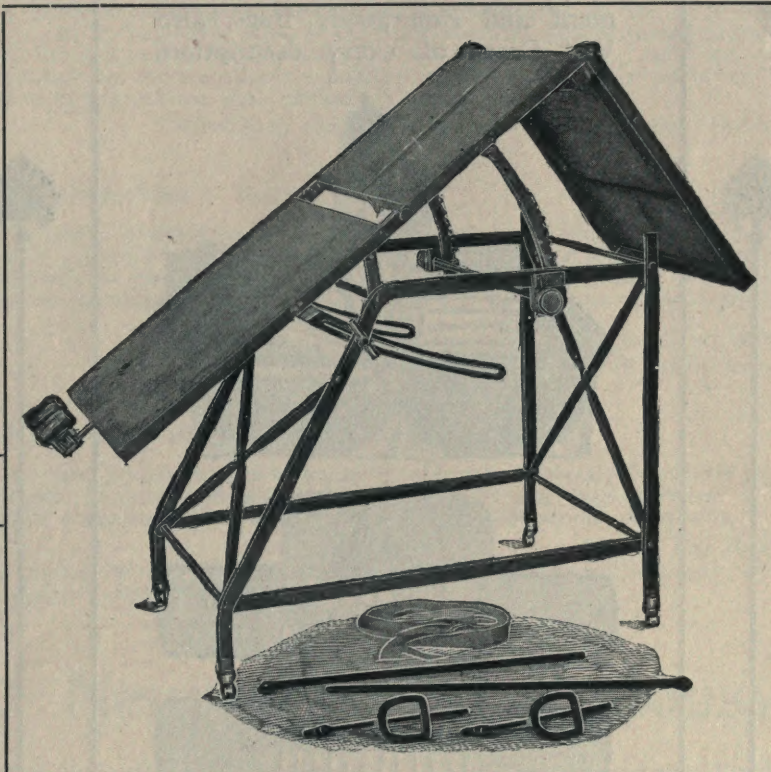
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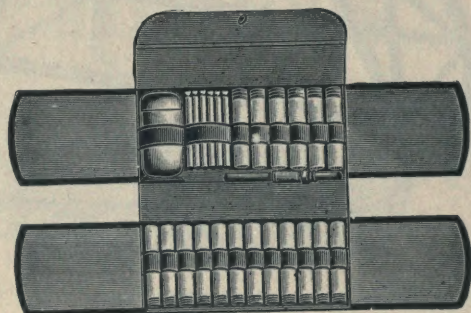
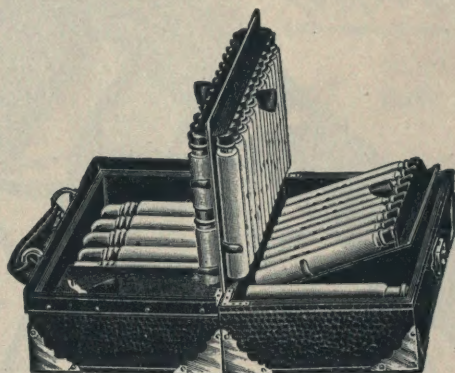
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Editorial by the late I. N. Love, M. D., in the "Medical Mirror."

Pains of Dysmenorrhea.

I have given Dioivurnia a fair trial and found it useful as an uterine tonic and antispasmodic, relieving the pains of dysmenorrhea and regulating the uterine functions. I feel authorized to give this recommendation of Dioivurnia, as it is neither a patented nor a secret medicine, the formula of which has been communicated freely to the profession.

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Prof. of Clinical Surgery and Surgical Pathology, Washington University; Prof. of Surgery, Post-Graduate School, St. Louis.

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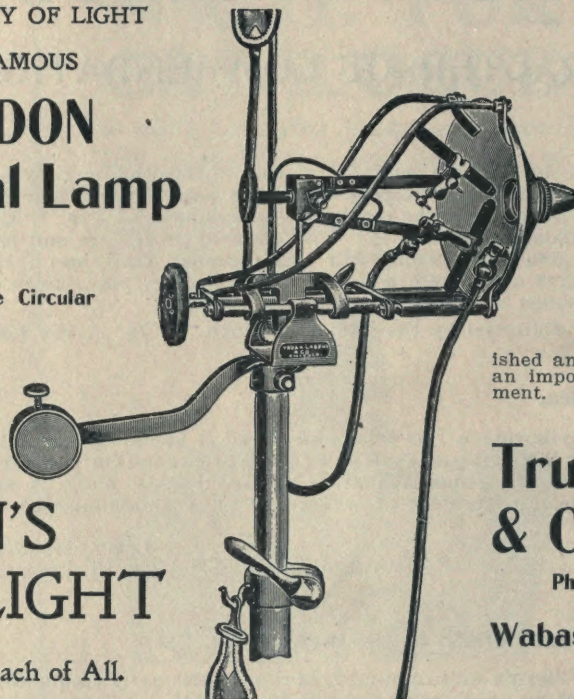
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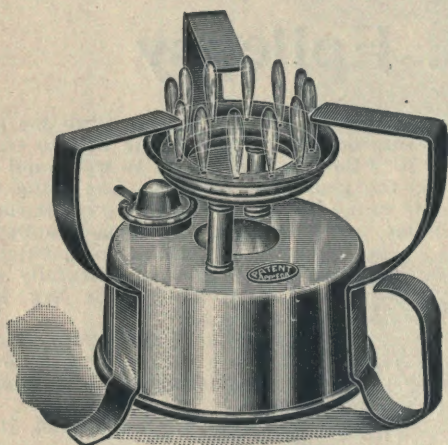
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A prominent physician recently recently remarked, "There was a time when nearly all the children I treated for pneumonia died. In recent years they all get well. The only change made in my treatment is that I now use Antiphlogistine in every case. Draw your own conclusions."

There are certainly some surprises in store for those not acquainted with the results following the proper application of Antiphlogistine in these cases. If the entire thoracic walls—front, sides and back, are covered with Antiphlogistine as hot as can be borne, fully an eighth of an inch thick and then covered with a good warm cotton-lined cheese-cloth jacket, results are immediately manifest. The pain and the rapid and difficult breathing are promptly ameliorated. The pulse improves, the temperature declines, the muscular and nervous systems relax, and the greatest of all remedial agents—rest

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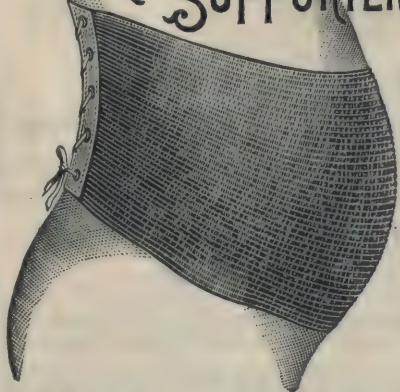
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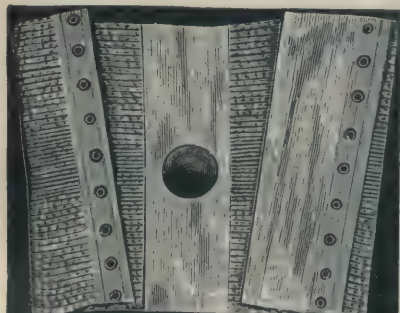
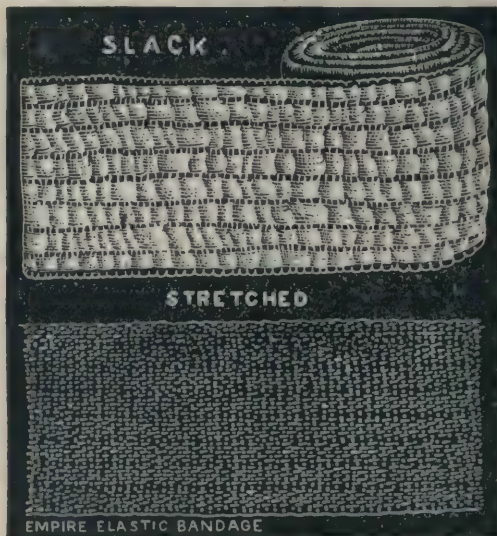
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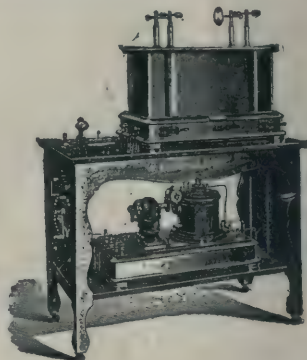
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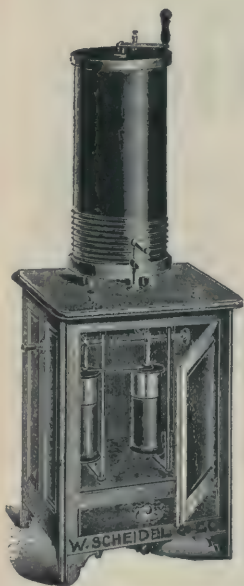


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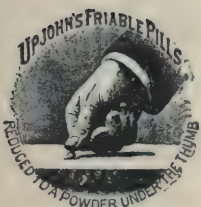
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THE RESULTS IN A SERIES OF FORTY-EIGHT KIDNEY FIXATIONS.*

By BENJAMIN R. SCHENCK, M. D.

(Late Resident Gynecologist, Johns Hopkins Hospital, Baltimore.)

There are few questions now before the profession on which there are greater differences of opinion than the significance and treatment of movable kidney. They are questions which interest the physician and the surgeon alike, and are of much importance to the gynecologist, on account of the great frequency of nephroptosis in women. In fact, they are important questions to everyone making physical examinations, and yet it is very difficult to formulate the answers, because of the widely varying opinions of eminent authorities.

On the one hand, there are those who believe that movable kidney is not of great importance, and that if treatment be required, simple measures suffice; on the other, those who think that a long train of symptoms may follow this condition, and operate on a large percentage of the cases which they see. The truth must lie somewhere between these extreme views, and it is only by the careful and detailed reports of cases that we can arrive at just conclusions. It is not my purpose this evening to discuss the whole question of nephroptosis and the various methods of treatment, but rather to describe one form of operation, and to present to you a series of cases treated by that method.

Most important for a true understand-

ing of this condition, especially from the standpoint of treatment, is a consideration of the normal supports of the kidneys, and the forces, mechanical and other, which tend to dislodge them. It is however, impossible within the limits of this paper, to go into these questions. Suffice it to say that recent work quite conclusively demonstrates that, whatever may be the significance of the commonly accepted factors in supporting the kidneys, such as the peritoneal folds, the adipose capsule and the effect of the intra-abdominal pressure, the configuration of the posterior abdominal wall plays a most important rôle, a shallow paravertebral niche, as is found in the female, predisposing to abnormal mobility of the kidney. Of the forces tending to dislodge the organ, the most potent is the often repeated mild trauma, such as the lifting of moderately heavy weights, the stretching of the muscles of the back, by repeatedly reaching forward, and the increase of intra-abdominal pressure by difficult defecation. The influence of relaxation of the abdominal muscles, especially following repeated pregnancies, is of great importance in causing enteroposis, and concurrent nephroptosis.

It is also impossible at this time to consider at length the diagnosis. I would like, however, to again call attention to a most valuable method for differentiating obscure cases. We are all familiar

*A paper read before the Wayne County Medical Society. Nov. 5, 1903.

with the woman, who comes to us complaining of back ache, indefinite abdominal pain, pain in the side, and a general run-down condition. On examination, little is found except a kidney, perhaps in the second degree of prolapse. Perhaps too, there may be some uterine displacement. Now, to what extent is the movable kidney responsible for the symptoms? Does or does not the obscure pain originate in the kidney? Kelly¹ has introduced a simple and satisfactory test. A renal catheter is inserted into the pelvis of the kidney, which in nine out of ten cases can be easily done. By means of an ear syringe, attached to the catheter, the pelvis is gradually distended with sterile water or boric solution, and when about 10 ccm. have been injected, pain in the side is complained of. Instantly, the patient will either recognize this pain as that from which she suffers, or will say that her suffering is different in character, or in a different location. We can thus definitely fix upon the kidney as the offending organ, or leave it out of consideration. The writer has seen this method give most satisfactory information in not less than forty cases.

As regards symptomatology, the cases of movable kidney may be conveniently divided into three groups:—(1) Those giving symptoms referable to the kidney itself. (2) Those presenting gastric symptoms. (3) Those in which the nervous manifestations are prominent. The following forty-eight cases have thus been classified and the results will be later considered.

Although the operation of nephropexy was first done by the late Professor Hahn of Berlin, the development of the operation has been principally here in America, and many modifications have been used.

It is not my purpose to discuss these various procedures, but to describe the operation devised by Kelly, and done by

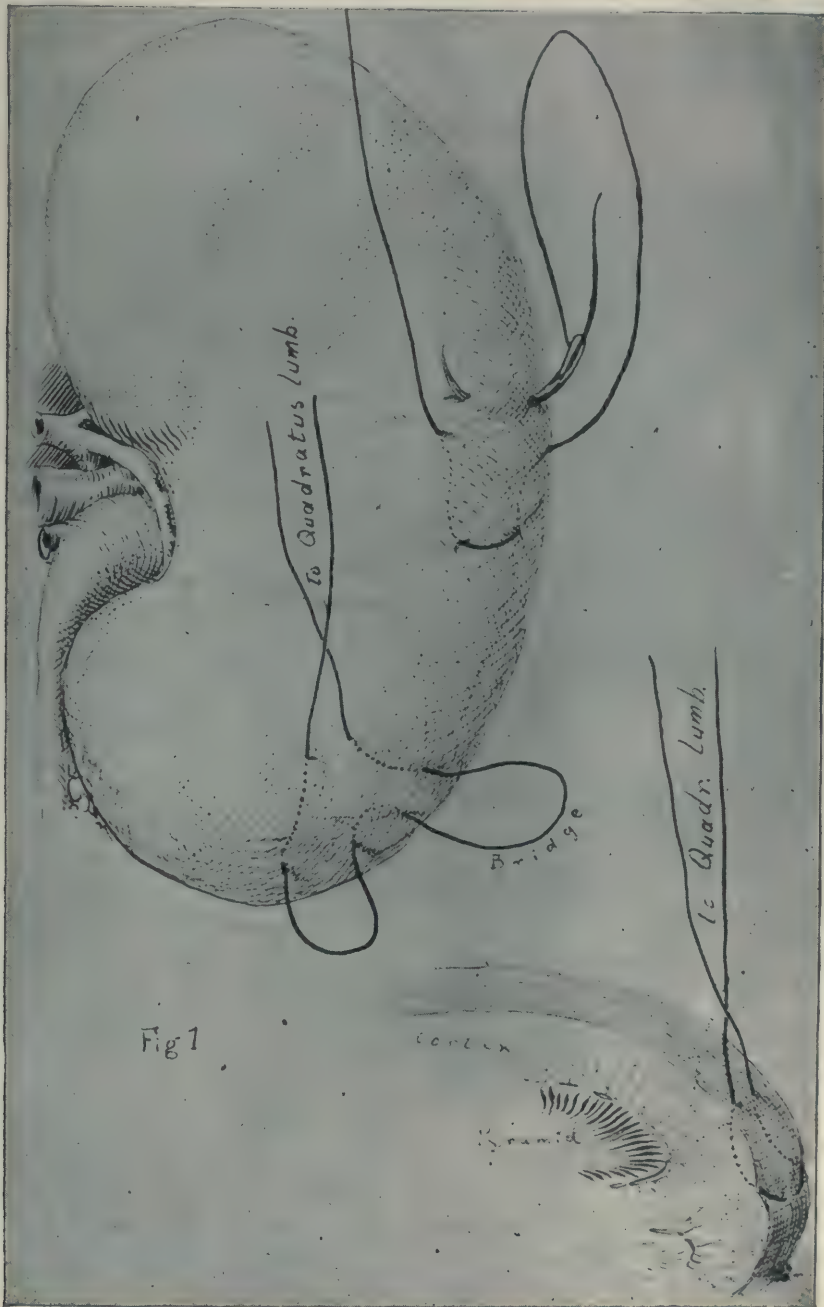
him and his assistants at the Johns Hopkins Clinic.

The technic is as follows:—With the patient lying on the side, over an Edebohls air-cushion, so placed as to push upward on the kidney, an incision is made downward and forward from the angle between the last rib and the erector spinæ muscle, for a distance of about three and one-half inches. The outer margin of the latissimus dorsi muscle will usually bisect this incision. This muscle is retracted mesially, or if broader than usual, may be separated longitudinally. We then have exposed the superior lumbar trigonum of Henle, having for its floor the transversalis fascia. This is incised and immediately the pararenal fat pops out. By applying numerous artery forceps, this fat is pulled upon, and the kidney thus brought into the incision. Küstner's capsule, (separating the para- and peri-renal fat) is next punctured, and the peri-renal fat comes into view. This layer of fat can be distinctly recognized by its color, which is some shades lighter than the outer layer. The kidney is now freed from the fat, and care taken to loosen it from the intestine, should the latter be adherent. To do this it is usually not necessary to bring the kidney out of the incision.

The posterior surface of the kidney is now to be sutured to the quadratus lumborum muscle, as shown in Fig. 2. For this purpose two or sometimes three silk sutures are employed, and these are inserted according to the method advocated by Broedel². After carefully isolating the first lumbar nerve, which usually runs along the margin of the quadratus lumborum, and retracting it on a blunt hook, the suture is passed through the muscle, and then beneath the renal capsule, as shown in Fig. 1, to again penetrate the muscle, where it is tied. A second, and sometimes a third suture is similarly inserted, thus bringing the posterior sur-

face of the kidney into intimate contact with the muscle. A curved, non-cutting needle should be used.

united with a suture of fine cat-gut, the latissimus dorsi muscle is restored, and the skin closed with a subcuticular suture.



The superfluous fat is now tied off, and all bleeding and oozing carefully controlled. The transversalis fascia being

In case the subcutaneous tissue is unusually thick, it may be brought together by a few interrupted sutures. No drain

is employed. The wound is dressed with silver foil, and sterile gauze, held in position by strips of adhesive plaster.

The following points should be carefully noted:

(1) The kidney must be detached from the intestine.

(2) The kidney must not be twisted by

and one-half cm. in length. This method of passing the sutures was used independently by Kelly and Goelet³, and has been found to sustain a weight, two and one-half times greater than one passed in the ordinary way.

(6) No mischief is done by the silk sutures, provided the asepsis is perfect.

During the convalescence, the patient should be kept upon the back, or upon the operated side, and should remain in bed for eighteen days.

While we see many papers on nephropexy, series of cases, reported after a sufficiently long time has elapsed, are comparatively rare. In the subjoined tables only such cases are included as have been operated upon at least one year, and the results are therefore more reliable than those of more recent cases. These patients were all treated at the Johns Hopkins Hospital, by Dr. Kelly, or his assistants.

The ages of these 48 patients ranged between 21 and 44 years. Thirty-two had never borne children. The right kidney was fixed in 37 cases, the left in 7, and both in 4. Letters have been received from all, and only such patients as reported that they are *perfectly* well, are so recorded. Those who are improved are very much improved, otherwise, are put down as no better.

In the first group of 25 cases, 18 are absolutely well, 4 are improved, and 3 unimproved. Nos. 11 and 15 were cases of general enteroptosis, in which the kidney was but one of the prolapsed organs. Case 17, one in which the operation was apparently clearly indicated, was a failure. Case 4 was entirely well until a pregnancy two years after the operation, and case 13, until a subsequent twin pregnancy. Cases 8 and 18 have been entirely relieved of pain and the dragging sensation, but report slight soreness at times on the affected side.



Fig. 2.

placing the sutures in the borders or the anterior surface.

(3) One of the sutures must be as near the upper pole as possible, to guard against the rotation of the kidney.

(4) The first lumbar nerve must be excluded from the sutures.

(5) The sutures must form two bridges over the renal capsule, from one to one

TABLE I. Cases giving symptoms referable to kidney.

No.	AGE	No. CHILDREN	SIDE	RESULT
1	44	4	R	W
2	34	3	R	W
3	25	0	R	W
4	29	2	R	I
5	33	2	L	W
6	24	0	R	W
7	21	0	R	W
8	43	0	R	I
9	38	0	R	W
10	43	0	L	W
11	29	3	R	O
12	26	2	R	W
13	31	5	R L	I
14	27	0	R	N
15	39	5	R	O
16	29	4	L	W
17	22	0	L	O
18	32	0	L	I
19	38	5	R	W
20	33	0	R	W
21	25	0	R	W
22	26	0	R	W
23	20	0	R	W
24	26	2	R	W
25	33	3	R	W

TABLE II. Cases giving gastric symptoms

No.	AGE	No. CHILDREN	SIDE	RESULT
26-1	26	3	R	W
27-2	24	0	R L	I
28-3	47	0	R	O
29-4	25	0	R	W
30-5	32	0	R	I
31-6	38	2	R	W
32-7	34	0	R	O
33-8	36	0	R L	I

TABLE III. Cases giving nervous symptoms.

No.	AGE	No. CHILDREN	SIDE	RESULT
34-1	25	0	R	O
35-2	28	0	R	W
36-3	22	0	R	I
37-4	26	0	R	W
38-5	34	0	R	W
39-6	33	0	R	I
40-7	24	0	L	O
41-8	36	0	R	W
42-9	31	0	R	I
43-10	27	0	R	W
44-11	32	3	R	O
45-12	21	0	R	I
46-13	30	0	L	W
47-14	36	0	R L	I
48-15	40	2	R	W

In the second group, 3 are well, 3 much improved, and 2 are no better.

Of the third group, 7 are well, 5 improved, and 3 unimproved.

If we may be permitted to draw conclusions from this number of cases, the following are justified:

(1) Operation is clearly indicated in the cases which, by careful differentiation, belong to the first group.

(2) When a general visceroptosis is present, operation is of doubtful value.

(3) A partial recurrence may follow a subsequent pregnancy.

(4) Cases belonging to the second and the third group are much benefited by operation, but the results are not so good as in the first.

The advantages of this method of operation are:

(1) It is the simplest possible suture method.

(2) The incision is short, and the kid-

ney is reached with minimum traumatism.

(3) The kidney is not injured.

(4) Painful scar tissue does not follow.

(5) It has no mortality, other than that of the anæsthetic.

(6) The results in properly selected cases are better than those of the more extensive and more dangerous operations.

I am indebted to Professor Kelly for permission to use this material, and to Mr. Max Broedel for the original drawings, which illustrated his article in *American Medicine*.

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502 Washington Arcade.

THE BLADDER SEGMENT OF THE URETER.*

By BYRON ROBINSON, M. D. Chicago, Ill.

During the rapid rise and progress of ureteral surgery the bladder segment or the distal extremity of the ureter has played an essential rôle on account of: (a), The intimate relation of the ureter to the bladder, vagina and rectum; (b), Because of the constricted lumen of the ureter at its entrance into the bladder, causing the lodgement of calculi; (c), Its exposure to trauma or incision during parturition and pelvic surgery, especially hysterectomy; (d), The distal ureteral orifice is of practical interest on account of ureteral catheterization; (e), It is accessible to palpation; (f), It is the portal for proximalward progressing bacterial disease. The distal end or bladder segment of the ureter comprises about $1\frac{1}{2}$ inches, viz: $\frac{3}{4}$ of an inch extramural and $\frac{3}{4}$ of an inch intramural.

For convenience of description and

*Written for the Detroit Medical Journal.

practical interest I shall divide the bladder segment or distal ureteral extremity into three parts, viz: 1, the extramural portion; 2, the intramural portion; 3, the distal ureteral orifice. The distal end of the ureter is the most mobile of ureteral segments, however, it moves with the trigonum vesicae and the enclosed fibromuscular ureteral sheath. The distal ureter is accessible for palpation, surgical and medical intervention, ureteral catheterization and inspection, extra-peritoneally per vaginam and per rectum. Perhaps the space between the ureter and ureteral sheath is a lymph space which facilitates the wide range of mobility of the distal ureter and also facilitates the spread of bacterial disease. Both intramural and extramural segments of the ureter are surrounded by the fibromuscular ureteral sheath which insures independent action of ureter and vesical wall.

In vaginal hysterectomy to avoid trauma to the distal ends of the ureters the bladder should be cleft from the uterus (crevix) and forced proximalward and the ureters proximal and lateralward.

The Extramural Vesical Portion

The extramural portion of the ureter about $\frac{3}{4}$ of an inch in length corresponds in general to the vaginal segment. It lies between bladder base and vagina. Distention of the bladder increases the length of the ureter applied to the vesical wall; however, the extramural portions remains the same in length and is firmly bound to the vesical wall by strong white connective tissue, nerves and vessels requiring vigorous dissection to free it. The extra-mural portion of the ureter is richly supplied by vessels, especially large veins, and the nearer it approaches the tractus genitalis the richer and larger the veins, in fact, this portion of the ureter penetrates a dense mass of tissue and plexuses of vessels. The extramural portion of the ureter is applied practically to the dorsal, lateral and distal surface of the bladder (base). The extramural portion of the ureter penetrates the vesical wall an inch distal to the os uteriexternum. It is palpable per vaginam, possibly per rectum in man. The strong musculo-fibrous ureteral sheath, Pantaloni's ureteral sheath, makes this portion of the ureter more palpable and serves as a protection against incision, laceration, ligature or clamp. The ureteral sheath is especially protective against trauma during parturition and particularly during cleavage of the bladder from the uterus in hysterectomy. The extramural portion is not of uniform caliber, but is spindle-shaped. On distention of bladder and ureter by air it forms a curve bending medianward previous to penetrating the bladder. For definite palpation of the extra-mural portion of the ureter per vaginam or per rectum in a man a ureteral

catheter should be previously introduced. In general the extramural portion of the ureter lies $\frac{3}{4}$ of an inch in contact with the bladder and vagina. Fistula of the distal end of the ureter is generally difficult to repair if the ureter be allowed to remain in situ. I know of one case of distal ureteral fistula extending over three years with umerous unsuccessful interventions. More or less distant ($\frac{3}{4}$ to 2 inches) from the extramural segment the distal arterio-ureteral crossing may be located per vaginam by palpation, but it is an indefinite landmark of the distal ureter, as it may be located 2 inches from the distal ureteral orifices and also the important "cervical loop" varies considerably in length, not only among individuals, but from functional relations also. The cervical loop may lie in contact with the extramural portion. The practical importance of the distal end of the ureter in diagnosis and surgery is in woman with the vagina (and crevix uteri) and in man with the rectum and vesiculae seminales. In hysterectomy, especially per vaginam or ligature of the uterine artery, the extramural portion of the ureter is not so liable to incision, or ligature because it is so firmly bound to the bladder by strong tissue and vessels—the ureter immediately distal to the distal arterio-ureteral crossing is the portion liable to damage in surgical intervention. In empty bladder the portio-extramuralis lies more dorso-laterally which makes the distal arterio-ureteral crossing more distant from the ureteral penetration of the vesical wall. If the bladder be distended the arterio-uter al crossing approaches the bladder wall. The pars extramuralis vesicae is the portion of the ureter which lies between vaginal and bladder wall, in contact with both, but can be safely freed from each. The extramural or vaginal portion of the ureter is of supreme importance, as it can be palpated

or attacked per vaginam, for surgical intervention, as the removal of ureteral calculi. I have removed ureteral calculus from the extramural portion per vaginam. During vesical distention the extramural portion of the ureter is forced lateralward closer and closer in contact with the uterine artery and cervical loop.

The Intramural Vesical Portion.

The distal end of the ureter penetrates the resting vesical wall obliquely for $\frac{1}{2}$ to $\frac{3}{4}$ of an inch as the intra-mural portion. It forms within the bladder walls a perfect non-regurgitating valve. It is the distal ureteral isthmus, perhaps the narrowest portion of the ureter and the frequent location of lodgment of ureteral calculi. I recently had two cases with lodgement of calculus at the intramural portion. On intravesical inspection one may note an oblique ridge extending from the distal ureteral orifice lateralward and proximalward on the vesical mucosa. This is the distal ureter, obliquely penetrating the vesical wall and projecting the vaginal wall into the so-called "ureteral folds" which may be observed on the ventral vaginal wall. The distal end of the ureter penetrates the tunica fibrosa and tunica muscularis of the bladder independently surrounded by a musculo-fibrous tunic (ureteral sheath). The independent penetration of the bladder wall by the ureter surrounded by its own ureteral sheath or musculo-fibrous tunic insures independent bladder and ureteral function i. e., the bladder progressively distends (diastole) while the ureter continually performs its peristalsis pouring its contents into the bladder when the bladder contracts (systole) expelling its contents, and ureteral peristalsis proceeds undisturbed. In other words, ureteral peristalsis and vesical peristalsis (diastole and systole, rhythm) proceed separately and independently. Urine may enter a distended bladder, but it cannot escape

by regurgitation on account of the oblique ureteral valve in the vesical wall. The bladder may be filled with air or fluid through one ureter while the other is unligated, unobstructed in its lumen, but no drop of water or bubble of air will escape from either ureter. The ureteral or vesical valve practically consists of an oval ring of vesical muscularis, surrounding the ureter as it passes through the bladder wall, and a lid or covering of vesical mucosa. The function of the valve is produced by pressure of the bladder contents against the mucosa or lid of the valve covering the distal ureteral orifice. As the bladder gradually distends by fluid or air the intramural portion, constituting the ureteral or vesical valve, gradually shortens until the bladder wall becomes as thin as cloth; the muscular portion of the valve is extremely short, but seems to retain its energy. However, the most apparent or efficient part of this wonderful non-regurgitant valve, the lid, is constituted by the vesical mucosa which shortens relatively less during vesical distention than the vesical muscularis. Hence in extensive distention of the bladder one can note that the vesical mucosa efficiently covers and protects the ureteral orifice from urine regurgitation or escape of urine into the ureter. During enormous vesical distention the non-regurgitating ureteral and vesical valve seems to adjust itself to the rapid changes of environments and retain its perfect integrity. With the highest bladder distention the fluid from the ureters passes with facility into the bladder, but not a drop regurgitates. The greater portion of the $\frac{3}{4}$ of an inch, the intramural portion of the ureter penetrating obliquely the vesical wall, lies immediately beneath the vesical mucosa while a more limited portion of the intramural segment lies within the grasp of the vesical parietal muscularis. Gradual distention of vesica urinaria shortens the segment of the ureter obliquely penetrat-

ing the vesical wall (muscularis) and gradually lengthens the vesical contact of the extra-mural portion of the ureter. The proximal ends of the intramural segment, i. e., the points of ureteral penetration of the bladder, are separated about $1\frac{1}{2}$ inches. I found by injecting numerous ureters with the canula from the bladder that the intra-mural portion of the ureter penetrated the bladder wall in a sagittal or dorso-ventral direction and that the distinct transverse traversing of the bladder wall by the ureter is an exception. Practically the transverse direction of the intramural portion begins in the submucosa vesicalis.

The Distal Ureteral Orifice.

The distal ureteral orifice generally opens significantly in the vesicle mucosa as a depressed oblique, oval, mucous, slit $\frac{1}{8}$ of an inch in length. It is distinctly visible to the naked eye, and located on a main milliform process at the proximal lateral angle of the trigonum vesicae. Sometimes it does not present an elevation, but on the contrary a depression in the vesical mucosa. The opening appears like a closed eye-lid, with considerable thickening of the edges of the lid at the proximal external end. The distal ureteral orifices stand one inch apart in the resting bladder, but in the well-distended bladder they may be separated four inches. This I have repeatedly demonstrated by experiment. At the proximal external angle of the mucous oval slit of the distal ureteral orifice there is an elevated thin mucous fold resembling a bridle rein which facilitates ureteral catheterization. The form of the distal ureteral orifice in general is an obliquely lateralward directed oval mucous slit about $1\frac{1}{7}$ of an inch in length, with the sharpest or most acute point of the oval directed medianward and distalward, while the thickened or more blunt end of the oval slit is directed lateralward and proximalward. The distal

ureteral orifice may be rounded, punctiform or like the beak of a flute. If it resembles the mouth of a flute the orifice is limited proximally and distally by a curvilinear mucous fold in the form of a valve constituted by the contact of the borders of the mucous fold. One can easily observe the advantages offered by this mechanical arrangement to facilitate ureteral catheterization. The elevated mucal ridge extending transversely from one ureteral orifice to the other—the inter-ureteral muscle of Jurie—aids ureteral catheterization. The ureteral orifice occupy the proximal lateral angles of the base of the trigone. The trigonum vesicae, constituted by the three orifices, two proximal ureteral and one distal urethral, is a mobile organ as a whole and also the separation of three mucous orifices varies within wide limits. The distance of separation between the distal ureteral orifices vary in the distending (diastole) and contracting (systole) bladder that figures given by different authors to fix the relation of the distal ureteral orifices in the trigone vary so much as to practically lose their value. If one consults a dozen authors it will be noted that the distance between the distal ureteral orifices as given by one author will be one-half times or double that of the other.

Thus one author will announce the distance between the distal ureteral orifices as $\frac{2}{3}$ of an inch, while another will proclaim that it is $1\frac{1}{3}$ inches. I have found in several hundred autopsies that the separation of the distal ureteral orifices varied considerably, depending on the age and sex of the patient and on the condition of the walls of the bladder. The extremes in autopsy may be stated as $\frac{2}{3}$ to $2\frac{1}{2}$ inches; however, the orifices may be easily separated four inches by distending the bladder by air or fluid. The female bladder allows the distal ureteral orifices to separate with more facility and

relatively wider than that of the male, which is fixed, protected and strengthened by the fasciae adjacent to the vesiculae seminales. In general the trigonum vesicae is an isosceles triangle of one inch (resting) and $1\frac{1}{2}$ to 2 inches (distended) bladder. The distal ureteral orifices are palpated with facility in woman after urethral dilatation. The color of the normal ureteral orifice is a pale gray; congestion and inflammatory disease may induce it to appear of a sunset red or maroon color. A contrast of color is observed when yellowish white pus flows from the ureteral orifice as viewed by the cystoscope in pyoureter. During life, intravesical inspection presents the mucous oval slit as more transverse in position than at autopsy. In bladders with thickened folded mucosa the ureteral orifice may be located on the crest of a fold or in the depression between two folds. The distal ureteral orifices form two of the angles of the trigonum vesicae (Lieu-taudii) and are located with the chief sensory nerves in the foldless mucosa of the trigone. If mucous folds existed in the

trigone they might aid in obstructing the urinal stream. The ureteral orifice necessarily blends with the vesical mucosa. The distal ureteral orifices are joined by a distalward curved transverse linear thickness, at the base of the trigone projecting a ridge of mucosa beneath which lie muscular bundles—the inter-uretero-muscle of Jurie. The trigone corresponds in space in man to the area of the vesiculae seminales in woman to the middle third of the ventral vaginal wall. In the use of the cystoscope one may expect to find the distal ureteral orifice about 2 inches proximalward from the external urethral orifice and a half inch lateralward. The distal ends of the ureters are located well proximalward in infancy and later may be proximal to the pelvic brim. In pregnancy and pelvic tumors the distal ureteral ends may pass proximal to the pelvic brim. During intra-vesical inspection with the cystoscope the ureteral orifices present themselves more prominently if the bladder be distended with air.

100 State Street.

METHOD FOR THE CURE OF STAMMERING AND STUTTERING.*

By GEO. ANDREW LEWIS, Detroit.

Mr. President and members of the Wayne County Medical Society:—It is only in comparatively recent years that the medical profession has looked favorably upon methods for overcoming speech difficulties—so many impostors having neither training nor experience have come into the field, pretenders to knowledge and skill which they did not possess. Their methods were empirical and for that reason it was the fashion to veil their treatment in mystery and secrecy, and only those paying fabulous prices were admitted to the benefits which oftentimes proved but chimerical. Indeed the history of the treatment of stam-

mering unfolds an interesting panorama. The great advance in methods has been proportionate with the gain made along other lines of education. He who stands at the front with those whose methods of treatment are progressive and who are bringing positive good to large numbers will emphasize the fact that the age of empiricism and mystery of method has passed. What is educational and based upon pedagogical principles need not be shrouded in mystery or secrecy, for right methods will bear the tests of scrutiny and criticism.

The problem of the cure of stammering has engrossed many minds in ages past—as have the causes of this wretched

*Read before the Wayne County Medical Society, Oct. 8, 1903

affliction. Stammerers are not born, but made. Heredity is only accountable for the predisposition which may lead to stammering. As Klencke says: "It is in every case a symptom—only a reflection of a predominating mental and physical disease." However, some mental or moral strain, inherited possibly from remote ancestors, coming in conjunction with certain physical conditions may produce such a peculiar inharmony that stammering or stuttering results.

It is certain that stammering is occasionally caused by the centers for nerves concerned in speech production becoming impaired through some nervous disease. Whatever exhausts the vitality and depletes the nervous energy opens the way for stammering wherever there is predisposition.

Broca, in 1861, made discoveries which he announced before the Paris Anatomical Society, which threw broad and definite light upon the location and functions of the motor speech area. He seemed to prove unquestionably that the power of expression in speech belonged to the left hemisphere of the brain.—That this emissive power in speech was so located was for the time stoutly denied by not a few eminent authorities. The region where concepts are converted into words lies in the third left frontal convolution which contains the motor speech centers.

Inasmuch as stammering is the inability, under certain conditions, to articulate, or control the organs of speech, which are usually, under such circumstances tightly compressed, it is the office of the teacher to find a means whereby misdirected effort may be overcome.

In order to find the desired means to free the speech we must trace speech to its origin, analyze the elements constituting it and thus seek out the real cause of the stammerer's affliction.

The evolution of speech may be resolved into several processes. Ideas, the

product of immediate sensations, or springing forth abstractly from the thought-center are all given orderly succession by the brain itself. Then the will determines the sequence of expressing these ideas. So far the activity is mental. Now comes the stimulation of the motor nervous system connecting the speech centers with the organs of articulation. The action thus stimulated and generated results in articulate speech.

Each activity is born of the preceding one and leads out in turn. As long as the sequence is uninterrupted and the harmony undisturbed there is ease and fluency in speech.

The question engaging the teacher of stammering is this: At what point is there a flaw in what should be a harmonious succession of activities? Careful investigation enforces the belief that stammering is of a more obscure origin than is generally conceded by the casual observer; the outward manifestations only are in the organs of speech. But the difficulty lies in the third step, in the evolution of speech. Experience with numerous cases, all differing in particulars as people differ in type and temperament, convinces me that the mental energy of the will has failed to generate into activity the stimulus of mind and body without which there cannot be that co-ordination and harmony which is necessary for the production of perfect speech.

From a repeated analysis of my own needs (having been a severe stammerer for over twenty years), and having had a chance to think, I found that the harmonious relationship between the mind and body in speech production is based upon certain principles. Obedience to certain laws gives inevitable results. The progress made seems little short of phenomenal to one not having an understanding of the science of speech production.

Seldom does stammering manifest itself in the same way in any two persons.

It is impossible to judge of the degree of suffering experienced by a stammerer by the physical manifestations. Some of the most deeply afflicted show very little of the deeply seated mental struggle which is being waged.

That struggle is occasioned by a fear of certain sounds in the language. These sounds so unbalance the stammerer that he is blocked in his attempt at utterance. The deeper his desire for expression, the more futile the results of his attempts—the harder the struggle for production, the greater the tension in the vocal organism and the farther he is from the production of the sound, the fear of which has upset his mental equilibrium.

Not all stammerers find difficulty upon the same sounds. A sound which would cause one extreme concern will be readily uttered by another. In examining the sounds of the alphabet, from the stammerer's standpoint, the consonants, owing to their formation, present the greatest difficulties. To the average stammerer the consonant sounds may be thus generally classified as to difficulty:—c, f, h, j, l, n, m, q, r, s, v, w, y, z, sh, th, ng, ch, wh,—present frequent trouble; while b, d, g, (hard); k, p, t, are very often sources of difficulty. Not always does the stammering come from attempts to utter single sounds—but from the endeavor to pass from one sound to another. To pass from a consonant which requires a closed position of the mouth to a vowel, requiring the open position, means a rapidity of action which seems to many a stammerer an impossible feat. Then again there are syllables, easy of utterance in themselves, but which are succeeded by those which are of such difficult formation that the stammerer loses his mental poise and stumbles. The majority of stammerers have each only a few specially difficult sounds—but the frequent occurrence of these in various

syllable combinations make them appear more than they really are.

To the stammerer the way out to free speech is perplexing and to one not informed as to methods, alleviation or complete eradication of the difficulty seems beyond belief. But the teacher knows that the difficult sounds must first be sought and the impediments therein presented and mastered singly. Then for discipline they must be confronted in combination with others until all undue effort has disappeared.

To meet the needs of every phase of difficulty arising among the variously afflicted stammerers, whether the object of fear be a closed consonant, a continuous sound or a vowel, the method of attack was formulated. By method of attack, I mean the mental and physical application of certain principles for the purpose of producing sounds, syllables or words difficult of utterance.

Closed Consonants.

According to Sweet, "A consonant is the result of audible friction, squeezing or stopping of the breath in some part of the mouth (or occasionally of the throat). The main distinction between vowels and consonants is, that while in the former the mouth configuration merely modifies the vocalized breath, which is therefore an essential element of the vowels, in consonants the narrowing or stopping of the oral passage is the foundation of the sound, and the state of the glottis is something secondary."

A careful examination of the relationship between the tongue and teeth in chart (Fig. 1) will illustrate the wrong action of these organs when one stammers on t, d, ch, j. It is apparent that undue effort has been put forth. What is the remedy? Note the correct position of the tongue and teeth in Fig. 2. This has been attained by taking the position as lightly as possible, touching only the tip

of the tongue against the gums and teeth—all of this being accomplished with as little physical tension as possible. This

obstruct the breath. In addition to words commencing as stated there are those beginning in p, b, (Fig 3) as well as k, g,

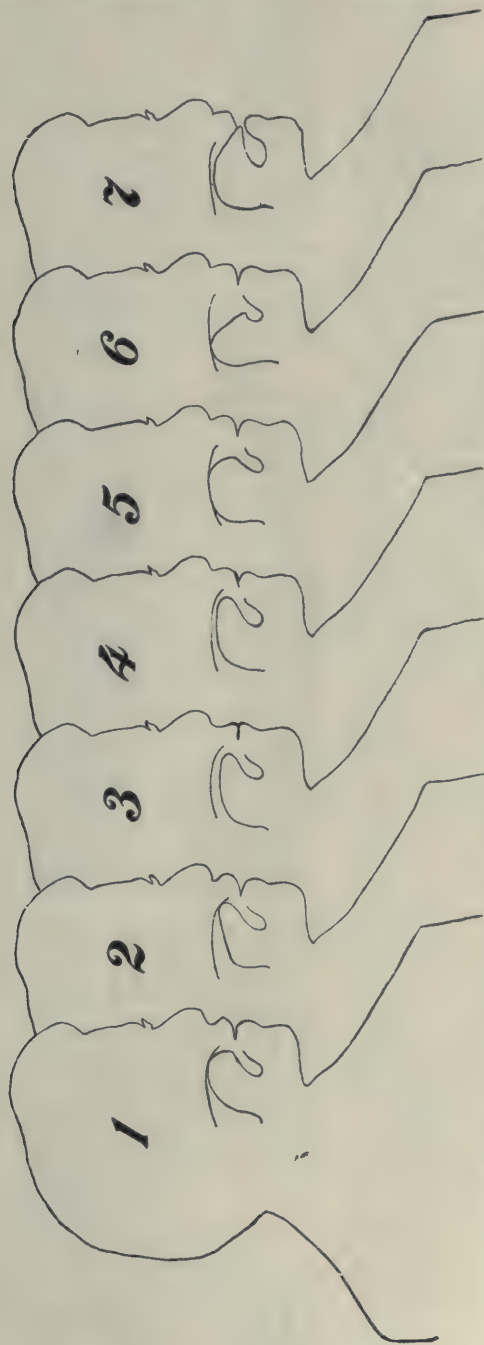


Fig. 1.—View of the mouth and throat showing position of the tongue in stammering on the sounds of the letters t, d, ch, j. (See Fig. 1.)
 Fig. 2.—Correct position of the tongue for the enunciation of words commencing with the letters t, d, ch, j. (See Fig. 1.)
 Fig. 3.—Correct position of the lips for the enunciation of words commencing with p and b. (See Fig. 4.)
 Fig. 4.—Correct position of the lips for the enunciation of words commencing with p and b. (See Fig. 3.)
 Fig. 5.—Correct position of the tongue in stammering on the guttural sounds k, g (hard), q. (See Fig. 6.)
 Fig. 6.—Correct position of the tongue for the enunciation of the guttural sounds k, g (hard), q. (See Fig. 5.)
 Fig. 7.—Position of the tongue in stammering on the continuous sound th. (See Fig. 8.)

principle is applicable to all sounds, syllables or words, the utterance of which, on account of excessive effort, entirely

and q, (Fig. 5). The correct position of the organs for the utterance of these sounds is shown in (Fig. 4) and (Fig. 6).

When the pupil has gone carefully over the means given him for overcoming the difficulties on closed consonants, he is one thing to meet difficulties singly, and quite another for the stammerer to face them in combination.

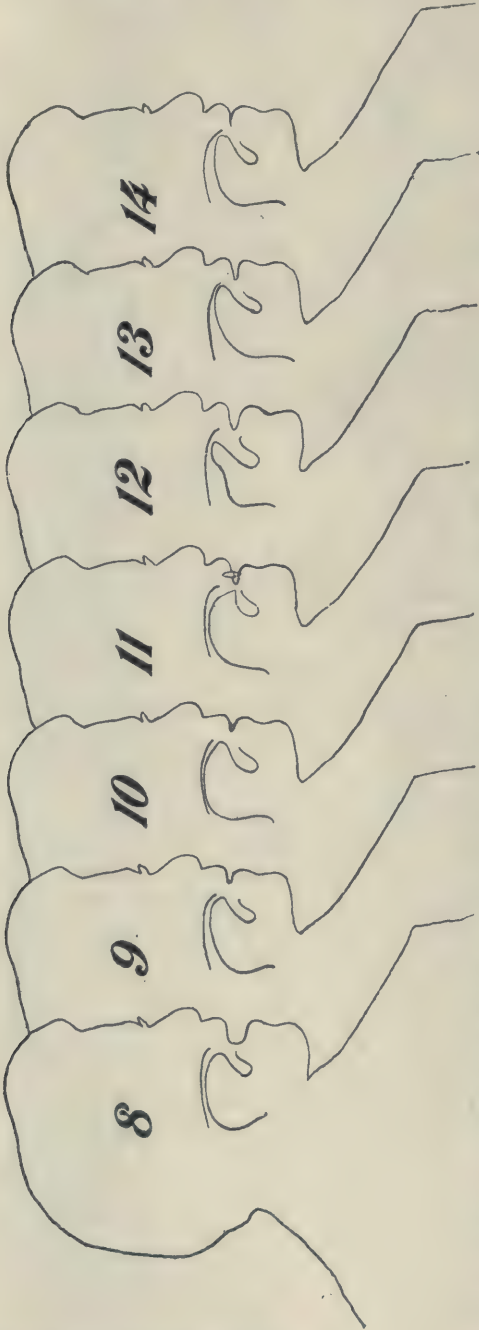


Fig. 8.—Having formed the initial sound, open the mouth, thus completing the word formation.
Fig. 9.—Position of the tongue and other vocal organs in stammering on the sounds of s and z. (See Fig. 8.)
Fig. 10.—Position of the tongue and other organs in stammering on the sounds of sh and zh. (See Fig. 8.)
Fig. 11.—Position of the tongue and other organs in stammering on the sounds of f and v. (See Fig. 8.)
Fig. 12.—Position of the tongue and other organs in stammering on the sound of the letter r. (See Fig. 8.)
Fig. 13.—Position of the tongue and other organs in stammering on the sounds of the letters l and n. (See Fig. 8.)
Fig. 14.—Position of the tongue and other organs in stammering on the sound of the letter m. (See Fig. 8.)

given some selection in which the closed consonants are marked for drill in the application of these principles, For it is

Continuous Sounds.

On account of the difference in manifestation, the method of attack for con-

tinuous sounds is very different from that for closed consonants. The wrongly directed effort in producing closed consonants completely obstructs the breath.

Stammering on a continuous sound manifests itself in one or all of three ways. (1) Escaping breath, (2) continuous effort at production, or (3) the continuation of the initial sound.

Experiment will prove that it is impossible to prolong any of the initial continuous sounds if the mouth is open. This opening of the mouth constitutes the method of attacking continuous sounds. Complete mental and physical relaxation are to be striven for.

Notice the position of the tongue in stammering on *th* (Fig. 7). (Fig. 8) shows the radical change, having fulfilled the requirements of the method of attack. (Fig. 9) shows the abnormal position assumed in stammering on *s* and *z* while (Fig. 10) illustrates the stammerer's fault in forming *sh* and *zh*. *F* and *v* give the position of the tongue shown in (Fig. 11) while stammering on *r* throws the tongue into the position illustrated by Fig. 12). When stammering on *l* or *n* the tongue and other organs assume the relationship indicated by (Fig. 13). Fig. 14 illustrates the stammering position on *m*. The same remedy for all these positions is suggested (See Fig. 8) in the open position of the mouth.

The stammerer is called upon to study carefully the manifestation of his impediment and then apply such portions of these suggestions as meet his needs. He who does this avoids thereafter much facial and bodily contortion. Then comes the general application—the marking of selections and dealing with continuous sounds combined with others.

Vowels.

So different is the manifestation of stammering upon vowels, there being a spasmodic contraction of the glottis, that this form of speech difficulty might be termed glottis-stammering. Charts and casts are used in demonstrating before the pupils, acquainting them with the lo-

cation and functions of the various muscles and organs involved in speech production. The physical manifestation of vowel stammering in some cases is a contraction of the glottis—a complete closing of the vocal cords. This activity of the vocal cords correspond to the compression of the lips and pressure of the tongue on consonants. There are cases in which vowel stammering is manifested in the inability of the speaker to vibrate the vocal cords. Now it is well known that a low tone is produced by relaxing the tension of the vocal cords, the denser the cord, the lower the pitch; and that a high tone is the product of cords thin and tense. Therefore the vowel stammerer finds relief by lowering the tone of voice on vowels, thus separating the vocal cords, and thereby freeing the glottis from all liability to contraction. If not absolutely remedial this manner of approaching vowels lessens the difficulty, whereas, for those unable to vocalize, a very important remedy is right control of the breath, to be acquired through practice of systematic breathing exercises.

The common sense treatment for the cure of stammering is many-sided. The method of attack is only one factor in the scheme of speech regeneration. At no time do we lose sight of the fact that everything in teaching and discipline must point to the fulfillment of the old saying, "A sound mind in a sound body." The keeping of good hours, right diet, systematic and regular physical exercise—all these enter into this problem of speech cure. A cure to be a cure must be based upon scientific laws involving a knowledge of physical, mental and moral needs. A system to be efficacious must subject the pupil to intelligent discipline. He must be taught that whatever destroys nervous equilibrium militates against his freedom of speech. He must be encouraged to build up his will-power until self composure proclaims its mastery by the ability to speak at all times and places without trepidation.

DETROIT MEDICAL JOURNAL

A MONTHLY EPITOME OF
PRACTICE AND THERAPEUTICS

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Medical Defense Against Blackmail.

Every physician engaged in active practice is liable to be confronted at any time with the charge of malpractice, frequently as an offset for a just bill for services rendered by him. Given the usual unsatisfactory result in a fracture involving a joint, an unexpected death from anæsthesia or following labor, a diagnosis and treatment in an obscure case, disputed or derided by the next physician called in, fortunate indeed is he who has not had payment refused and retaliatory suit threatened if he continues to consider his services of any value whatever. We have no means of knowing just how frequently this occurs, but we suspect not unfrequently. And in most instances the physician shirks his professional duty and crosses off the charge rather than meet the bother, expense and notoriety of a possible suit. Nearly all such cases are legally blackmail, because the courts demand of a physician only ordinary skill and care, with no guarantee of results; hence there is no legal offset in an unsatisfactory result of treatment, so long as the remedial measures employed have the endorsement

of the profession, and ordinary skill has been used in their application. Moreover, if the layman has sustained any damage in the legal sense the amount is far in excess of the doctor's bill and his willingness to compromise for that small sum is conclusive evidence of the weakness of his case. The instances are rare indeed, in which the physician, by reason of his diagnostic errors or therapeutic mistakes, renders himself legally liable for damages therefor, and yet the defense of his reputation and purse against such an action involves endless bother and worry and much expense.

So far as we remember, there has seldom been a successful malpractice suit in Michigan, yet many have been brought—for the hope ever lives in the mind of an unscrupulous attorney that the doctor may compromise rather than stand suit—and, unfortunately, precedent favors this opinion. That this menace to the peace of mind and the scanty purse of the practitioner is a growing one, there seems little question. Is there any remedy at our command?

In the first place, most of these blackmailing attempts have their inception in professional jealousies or rivalries. The chance word of criticism, even when unpremeditated, often creates dissatisfaction with services well rendered, but the malicious innuendo is certain to do so when misfortune has followed the best of treatment. The first remedy, then, lies in the assiduous cultivation of *esprit de corps* and unity in the profession. When the time comes that every reputable physician is a member of his county and state society, malpractice suits or threats thereof will be much more infrequent. In the second place there should be an organized effort by the medical society—the state society at least—to take care of these matters in a general way for its members, as the Chicago Medical Society is now attempting to do, by

founding a Medical Defense Fund with money from the common treasury or, if necessary, by a slight increase of dues, or even by an occasional special assessment. With a reliable firm of attorneys engaged by an annual retainer to defend its members up to actual trial in court, but few pettifoggers would be bold enough to fight practically the whole membership of the State or even the County Society, except with a case of actual malpractice, which rarely occurs.

We believe such a plan is feasible in all large societies and are watching the working out of the Chicago experiment with interest.

In the third place, until the test of time demonstrates the feasibility of a defense fund available to the whole profession through the Medical Society, it is the duty of every man to insure peace of mind, unsullied honor, and the retention of his hard earned and honest dollars as he insures his life or furniture. There are a number of reliable companies which for a greater or less consideration contract to indemnify him for damages allowed—or to defend him if sued or threatened. He should read his contract carefully and secure what he wants most, which we take to be protection rather than indemnity, protection to his reputation and pocket-book, rather than reimbursement for possible damages which the courts almost never allow. As said before, actual errors and mistakes are so seldom proven in court that one reasonably well read and trained need have no fear of not ultimately winning, but the annoyance, worry and expense of such an attack against his most valuable asset—his professional reputation—is certainly to be avoided if possible.

A Liberal Proposition.

Our Colorado brothers of the Homeopathic persuasion are not to be outdone

in courtesy by the sectarian American Medical Association, for with a polite "After you, my dear Gaston," the following resolutions were adopted at their last meeting:

"Whereas, the American Medical Association has recommended the admission of homeopaths to membership in all allopathic medical societies throughout the United States on condition that said homeopaths shall first agree to drop the name homeopathy from any public or private use in their business and professional capacities; and

"Whereas, we believe that our allopathic brethren are much more ignorant of homeopathy than we are of allopathy; and

"Whereas, we believe that a knowledge of the truths of homeopathy would be of the very greatest benefit to the allopathic school and the patrons thereof; and

"Whereas, we desire, in the spirit of true fraternity, to reciprocate the courtesy which has been extended to us: Now, therefore be it

"Resolved, that the Colorado Homeopathic Society, in convention assembled, on this, the 17th day of September, 1903, hereby extends a cordial invitation to all allopathic physicians in good standing to become members of this society, on condition that they shall agree to investigate the law of homeopathy, and to give in a fair and impartial test in practice.

"Resolved, that this society hereby recommends that all homeopathic societies throughout the state of Colorado and throughout the United States shall pursue a similar course and extend the privilege of membership to all who will accept it on the above condition."

The Health of Large Cities.

The report of the Detroit Board of Health for the fiscal year ending July 1 contains many statistical data of medical interest. The Board has had an epidemic

of mild small-pox to fight, over 1,000 cases occurring with but 12 deaths, all in persons who had never been successfully vaccinated. In stamping out this disease vaccination proved very efficacious, about 80,000 people consenting to protection at the public expense.

Diphtheria showed a mortality of 15.5 per cent., with a total of 976 cases, scarlet fever a mortality of 5.5 per cent. in a total of 598 cases. Detroit has the lowest death-rate from typhoid of any city in the country of its size, and stands eighth in the list of 130 cities of over 30,000 inhabitants—certainly a good recommendation for pure drinking water.

Pneumonia and other acute diseases of the respiratory tract caused twice as many deaths as phthisis, corroborating the experience of Chicago and other large cities in this respect.

Antitoxin is furnished gratis to the poor, the water and milk supply is closely watched, and numerous bacteriological examinations made for Loeffler's bacillus and the bacillus tuberculosis as a diagnostic aid to physicians.

The value of such efficient Boards of Health to the public is inestimable and under such paternal watchful care the public health of urban populations is constantly improving.

EDITORIAL NOTES.

The review of the subject of high arched palate by Dr. Swain suggests some practical points. 1st, The deformity may be avoided by removing the anterior nasal and posterior nasal obstruction at an early age, before the process of ossification is complete, which is somewhere near the eighth year.

2nd, That inheritance, traumatism and malnutrition are not the only causative

factors; that nasal stenosis is the most prominent factor; and that an inherited adenoid habit may be practically corrected by operative procedure at a time when the bones and cartilage are still plastic, which is from birth to the eighth year. Operations performed at an early period are followed by good cosmetic effect and effectually prevent deformed palate and irregular eruption of the teeth.

3rd, Failure to operate early results in maldevelopment of the facial bone and nasal cavity, substitution of mouth-breathing and catarrhal states of the mouth, the throat and the gastro-intestinal tract. Through disuse of the nose the adenoid expression is established, which consists of vacant face, open mouth, hanging jaw, nasal discharge, disturbed sleep and snoring, diminished hearing, recurring headaches (in older children), high, arched palate, irregular eruption of the permanent teeth and deformity and lack of development of the chest.

4th, The symptoms of chronic nasal or post-nasal obstruction occur when by day or by night the nasal respiration is supplemented by mouth-breathing.

The thirteenth annual meeting of the Mississippi Valley Medical Association, will be held at Cincinnati, Ohio, October 11, 12, 13, 1904, with Dr. B. Merrill Ricketts as chairman of the Committee of Arrangements.

The following resolution was offered by Dr. S. P. Collings, of Hot Springs, Ark., at the Memphis meeting, and adopted:

"Whereas, The value of perfect sight and hearing is not fully appreciated by educators, and neglect of the delicate organs of vision and hearing often leads to disease of these structures, therefore be it

Resolved, That it is the sense of the Mississippi Valley Medical Association that measures be taken by Boards of Health, Boards of Education and school authorities, and where possible, legislation secured, looking to the examination of the eyes of all school children, that disease in its incipency may be discovered and corrected."

Dr. William Shaw Stewart, one of the founders and a former dean of the Medico-Chirurgical College, of Philadelphia, died at his home, 1725 Pine St., Philadelphia, on November 25 last. Dr. Stewart was born at Stewart's Station, near Pittsburg, in 1838, and graduated in medicine from Jefferson College in 1863. He served in the Civil War as assistant surgeon in the Federal army, and on the declaration of peace began practice in Philadelphia. He gained much distinction in his chosen profession, was a member of several important medical societies, and twice a delegate to the World's Medical Congress. He was a regular contributor to a number of prominent medical journals of this country. At one time he held the professorship of obstetrics and gynecology at the Medico-Chirurgical College, and was professor emeritus at the time of his death.

The *Chicago Inter Ocean* gives the following account of the trial of Dr. Arthur C. Probert, one of the heads of the Chicago "certificate mill.":

"Dr. Arthur C. Probert, vice-president of the Christian Hospital of 617 LaSalle avenue, was fined \$500 and costs by Judge Kohlsaat for fraudulent use of the mails. Probert was arrested several months ago on complaint of Dr. John B. Murphy and others, who said their names were being used without authority on "certificates" of the hospital, so that other physicians might be swindled.

"The indictment under which Dr. Probert was punished in the Federal court charged him with having defrauded Dr. John A. King, of St. Louis, Dr. Ambrose Clum, of Minneapolis, and Dr. C. C. Blanchard, of Delavan, Wis. Circulars were sent out from the hospital on the North Side inviting physicians in all parts of the country to become members of the staff on payment of fees averaging about \$25.

"The indictment charged that false representations were made to the victims by the use of names of reputable physicians and surgeons who were supposed to be connected with the hospital."

Dr. George J. Engelmann, of Boston, Mass., one of the best known gynecologists in the country, died at Nashua, N. H., on November 16 last. He was born in St. Louis, Mo., fifty-five years ago, but had made his home in Boston for the past six years. He held numerous important positions in gynecological societies in his lifetime; he was founder and president of the St. Louis Obstetrical Society, president of the Boston Obstetrical Society, president of the Southern Surgical and Gynecological Society, 1890; founder and president of the American Gynecological Society, 1900; honorary president of the gynecological section of the international medical congress, 1884; honorary president of the international congress of obstetrics and gynecology, Brussels, 1892, Amsterdam, 1899, Rome, 1902.

Thanks to the generosity of Sir Ernest Cassel, who furnished \$1,000,000, the corner-stone of the King's Sanatorium for Consumptives has been laid by King Edward at Midhurst. A site of 150 acres has been secured in Sussex county in the heart of a pine forest, at an elevation of 650 feet. One hundred beds are to be provided, of which 88 will be devoted to patients who can pay but \$5.00 a week,

and 12 for patients who are better off financially, who will pay as high as \$25.00 a week. The entire building is laid out along the most modern lines, and its cost, completed, is estimated to be in the neighborhood of \$400,000. There were imposing ceremonies in connection with the corner-stone laying.

As one result of the high mortality from pneumonia in Chicago this fall, the health department officials of that city are seeking to arouse interest in a national movement to check the prevalence of this disease. They point out, with some justice, that pneumonia is sudden in its attack and that death from it is by no means a lingering one, with the result that the sufferings of the patient are not called to the attention of the profession as a whole, or to that of the public, as are those of tuberculosis. While they applaud the anti-tuberculosis crusade, they sound a note of warning that effective measures must shortly be taken against pneumonia, in order that it may not become a greater scourge than consumption ever was.

M. G. Demeny, a French scientist, is the inventor of an apparatus for taking a mould of the human body which should be of lively interest to those interested in orthopedic work. It consists briefly of a series of strips of wood, movable about an axis which may be attached either to a frame or to the back of the patient. The distal ends of the strips are brought into contact with the body, and rendered immovable by a system of clamps. The axis is then removed in order that the contour of the body may be shown on paper. The inventor makes use of thin strips covered with a layer of dried glue. These are moistened in warm water, and when brought into contact they adhere, preserving their respective positions, and when dry they show abso-

lutely the contour of the body between the tips. Arrangements may be made for using two apparatus at the same time, parallel to each other, and thus securing the form and the vertical section of the trunk of the anterior, posterior and lateral aspects of the body. For horizontal sections four rods are employed, with strips so arranged as to form a frame into which the body may be introduced. The apparatus is certainly ingenious, and should prove of much value.

In an interesting article published in the December number of *World's Work*, Dr. Frank P. Foster, editor of the *New York Medical Journal*, names some of the American surgeons who have done the most to advance the science of surgery. On the roll of honor he places the name of Dr. Theodore A. McGraw, of Detroit, together with those of Dr. William S. Halstead, of Baltimore, and Dr. John B. Deaver, of Philadelphia, for what they have done in connection with operations on the liver and the biliary passages. He also comments favorably on the use of the McGraw ligature.

At the fifth annual meeting of the Ohio Valley Medical Association, held at Columbus, Ohio, on November 13, the following officers were elected: President, Dr. A. M. Hayden, of Evansville, Ind.; first vice-president, Dr. W. J. Stone, of Henderson, Ky.; second vice-president, Dr. C. T. Hendershot, of Cannelton, Ind.; third vice-president, Dr. August Schachner, of Louisville, Ky.; secretary and treasurer, Dr. A. J. Lieber, of Henderson, Ky.

Dr. Cyrus Edson died of pneumonia in the Roosevelt Hospital, New York City, on December 2. He was born in Albany N. Y., in 1857, and became a prominent member of the medical and the pharmaceutical boards of the metropolis. He was a well known author on medical and sanitary subjects, and was the inventor of a number of surgical appliances.

NEW INSTRUMENTS AND DEVICES.

Mention of new instruments and devices in this department is entirely complimentary and articles illustrated are judged on their merits.

We invite manufacturers and physicians to send us matter suitable for publication under this head. A description of the device and an electrotpe or half-tone with a base not greater than two and five-eighths inches should be sent.

Always mention the price of the article in question.

The management cannot undertake to return cuts unless postage for same accompanies the letter with which they are sent.

CURVED ABDOMINAL HOT WATER BAG.

This device, designed by Dr. Fenton B. Turck, is intended for intra-abdominal use during an abdominal section. It



acts as a hot water pad and at the same time as a coffer-dam to the viscera in the field of operation. It is made of fine para rubber, seamless, and readily fastened at the neck with a tape or a string. It is sold for the sum of 75 cents, and is well worth the price.

McGaw Aspirator.

This device is made on an entirely new principle, and differs materially from other apparatus designed for the same purpose. The stop-cock and bottle are done away with, and simplicity and compactness are secured. The contents of the cavity to be evacuated are drawn into the pump and automatically discharged into a basin or other receptacle. Its construction does not interfere with its use for injection purposes.

When packed for shipment, the aspirator is mounted on a metal rack and enclosed in a leather case. It retails to the profession for \$7.00.

The American Electro-Medical Society held its first annual convention in the Masonic Temple, Chicago, November 30 and December 1, 2 and 3 last. A number of interesting papers were read.

Dr. David Bovaird, Jr., has severed his connection with the *Archives of Pediatrics* of which publication he has been associate editor for some time. He is succeeded by Dr. L. E. LaFetra, of New York. Dr. Bovaird intends to devote his time to hospital work.

President Harper and Dr. Small, of the University of Chicago, have issued a warning bulletin to students of the University, recommending that all water used for drinking purposes be boiled and filtered. There are a few cases of mild typhoid in the institution, and the faculty is desirous of heading off an epidemic.

Philadelphia is suffering from a general invasion of small-pox, which is assuming an epidemic form among the unvaccinated. In one period of two weeks, ending November 28, the number of new cases reached 138, the highest since the small-pox epidemic of two years ago. The physicians of the city are making a strong demand for general vaccination.

PROGRESS OF MEDICAL SCIENCE

Medicine and Therapeutics.

Dietetic Treatment of Nephritis.

Victor C. Vaughan (*Northwest Medicine*, September, '03), believes that in certain forms of nephritis, at least, the disease is due to the toxicity of the blood serum, exerting a specific action on the renal cells, which belief is supported by strong experimental evidence. If this is true, then the treatment, hygienic and dietetic, should aim to alter the proteid constituents of the blood. Under certain conditions drugs, such as digitalis, elaterium or mercury, are of decided value, but the main treatment should be dietetic. He says:

"The diet which I have found most serviceable in chronic nephritis is, with the exception of cream and butter, wholly vegetables. I forbid meat in any and every form, eggs and milk. As I have already stated, the object which I desire to accomplish is to profoundly alter the proteids in the circulating blood, and both theoretically and clinically I believe that I have the best of reasons for the selection of this diet. The urine for twenty-four hours should be collected and the quantity of albumin in it should be accurately determined, and the result expressed both absolutely and in percentage. At the same time the amount of urea and of total nitrogen should be ascertained. Then the patient should be placed on the diet and after three days or longer, corresponding analyses should be made. The diet permits cream, which should be separated from the milk as completely as possible, and should not contain more than one per cent. of proteid, and the amount of cream allowed per day is limited to 500 grams, or one

pint. Corn meal mush I prefer among the cereals, and this is allowed *ad libitum* and oat meal or cracked wheat may be substituted. Sugar is allowed *ad libitum* for the mush, and zweiback and butter and potatoes complete the substantials of the ration, although I permit the legumins, peas and beans, either fresh or canned, green vegetables, fruits and melons. There is no difficulty in living on such a diet, and after a few weeks patients lose all desire for meat and eggs and wonder why they were formerly so fond of them. That the necessary calories are furnished by this is shown by the following table:

	Proteid	Carbo-Hydrate	Fat
500 grams of cream....	5	27.60	150
200 grams corn meal...	20	130.60	8
100 grams zweiback....	14	60.00	24
50 grams butter.....			40
20 grams sugar.....		20.00	...

Total 39 238.20 222

"This gives 39 grams of proteid, 238.2 grams of carbohydrate and 222 grams of fat. The caloric value of each gram of proteid and carbohydrate is 4.5 and of each gram of fat is 9; therefore these calories represented in this ration are shown by the following figures:

$$\begin{array}{rcl} 39+238.2=277.2\times4.5=1274.4 \\ 222\times9 & = & 1998.0 \\ & = & \\ & & 3245.4 \end{array}$$

"It will be seen that this ration furnishes more than 3,000 calories, and we have taken no account of fruits and melons. Furthermore, the proteids can be increased by substituting in part legumins for cereals, or by substituting oat meal or

wheat for the corn meal. I have had hard working men live on this diet with ease, and at the same time the amount of albumin in the urine has gradually decreased."

F. B. T.

Scarlet Fever.

Baum (*Journal American Medical Assn.*, October 10, 1903), summarizes the hospital cases of scarlet seen by him during the years 1896-1903. There were 628 cases, 307 males, 321 females, with 44 deaths (7.07 per cent). Of the complications, suppurative otitis media occurred 11 times, nephritis 47, pneumonia 19, arthritis 2. In 35 per cent. of all cases there was some pain in the ear. Albumin was present in 37 per cent. of all cases during the early stages, though only 7.6 per cent. showed true nephritis. In three cases there was present at the beginning, or on the second day of the eruption, a septic nephritis, with much albumin and many casts. These cases were all fatal.

Most of the nineteen pneumonias involved the upper lobes; bronchitis, with broncho-pneumonia at times, was present in nearly all severe cases.

Two cases showed severe arthritis; in twenty-one other cases there was slight joint swelling, unaccompanied by other symptoms.

There were 142 cases of mixed infection (22.7 per cent). In the mixed infection the mortality was 11.9 per cent.

Ninety-six of these mixed infections were diphtheria, though in many cases the diphtheria appeared as a secondary infection during early convalescence.

Twenty-nine cases were of complicating measles, thirteen of varicella, three of parotitis and one of diphtheria and measles.

Regarding diagnosis, drug eruptions, as caused by belladonna, quinine, copaiba, chloral and opium, as well as toxic erythemata, must be considered. A point of

diagnostic importance in this connection is that the glandular swellings, characteristic of scarlatina, are missing. The drug eruptions may, however, be accompanied by fever. Cases of rubella are at times mistaken for scarlatina, but in this condition the rash is always measly, never confluent.

Reviewing the literature concerning the specific etiological factor of scarlet fever he concludes that no definite proof has yet been brought forward that any one of the organisms is the actual cause.

F. B. T.

Hypodermic Use of Mercury in Syphilis.

Collings, of Hot Springs (*Interstate Medical Journal*, November, '03), considers hypodermic treatment indicated wherever it is necessary to bring the patient rapidly under the influence of mercury, as in cases of a malignant type or of rapidly destructive lesions, of impending paralysis or in cerebral syphilis. The pain produced is the main objection, but this is largely obviated by the following mixture:

Hydrargyri

bichloride, C. P.	grams 0.50	grs. viiss
Sodii chloride.....	" 0.25	grs. iv
Aqua destil.....	" 4.00	fl. 3 j
Mix. ft. sol. (gentle heat)		
Chloretone	grams 0.50	grs. viiss
Aqua destil.....	" 2.00	fl. oz. ii
Absolute alcohol..	" 1.00	min. xv

Dissolve chloretone in 20 c. c. distilled water, add alcohol, and, finally, add hydrg. and sodii sol. Shake well and filter.

This makes a 1 to 50 solution of the bichloride, of which ten minims would represent one-fifth of a grain. It may be given in doses from five minims up to twenty or even twenty-five.

The chloretone is not readily soluble in cold water, and the above solution is made by the addition of a small amount of absolute alcohol, in which it is very

soluble. This formula is practically painless. Ordinarily, a patient will stand ten minims every day for four to six days, then a larger dose should be given every second or third day, or possibly once or twice a week as the symptoms demand. The post-trochanteric region should be selected to give the injections, and they are given deep into the muscular tissue, the skin being disinfected by being briskly rubbed with a piece of sterilized or carbolated gauze saturated with alcohol.

F. B. T.

Surgery and Gynecology.

Kidney Fixation.

Goulet (*Journal A. M. A.*, November 7, 1903), argues strongly in favor of the operative treatment of prolapsed kidney instead of attempts at fixation or support by means of corsets or belts. The kidney is normally movable downward an inch or more, being restrained from further descent only by its surrounding fat and the vessels entering the hilum, and may be dragged further down by a prolapsed colon. Belts are not without value in the earlier stages of mobility, before the kidney has descended below the rib in front, but after such descent are positively injurious because of the irritation to the kidney from pressure, necessary to afford effective support, which certainly provokes undesirable irritation and eventually leads to serious inflammation in or about the kidney.

In operating, he completely detaches the fatty capsule from the kidney, thus freeing it from the colon and the duodenum in front, but does not loosen or even scarify the fibrous capsule. Firm adhesion of the kidney, with its fibrous capsule intact, can be invariably secured if the kidney is held immovably in contact with the lumbar muscles for a sufficient length of time. The sutures, two in number, are of silk-worm gut, inserted practically as advocated by Dr. Schenck in

another column, and are left in twenty days.

The wound is closed in tiers and the sustaining sutures tied over a small pad of gauze to prevent cutting into the skin and loosening of the loop. The wound should always be drained by a strip of gauze packed around and under the lower pole of the kidney, to be removed in 48 hours. Goulet has fixed 159 kidneys without a death or a failure.

The cause of failure of this operation may be found under one or more of the following heads:

1. Delay in operating until the kidney has become seriously disabled, or an incurable nephritis has developed, or the health of the patient and his digestive apparatus seriously impaired.
2. Unusual and irreparable ptosis of the abdominal organs as a complication of nephroptosis. In these cases, however, since the kidney is many times the most important element of the enteroptosis, fixation of this organ and support of the others by belt places the patient in a comparatively comfortable condition.
3. Failure to detach completely the fatty capsule from the kidney—that on the posterior surface to permit the kidney to come into contact with the structures to which it must become adherent, and that on the anterior surface so as to separate the attachment of the colon and duodenum on the right side and colon and pancreas on the left. Unless this detachment of the bowel from the kidney is complete there will still be dragging on the kidney, which, if it does not pull the kidney away from its attachments, will give rise to annoying pain and other symptoms.
4. Improper insertion of the sustaining sutures, whereby they either tear out completely or cut through the fibrous capsule and permit mobility of the kidney before it can become permanently attached.
5. Failure to immobilize the kidney un-

til it can become permanently attached by adhesive inflammation, either by improper tying of the sutures or the use of suture material that stretches when it becomes softened after being buried in the deep tissues of the back or absorbs too quickly, or by fastening the retention sutures to the soft structures only, which yield to the construction of the suture, allowing the loop to loosen.

6. Too early removal of the retention sutures.

7. If the remaining fatty capsule is permitted to become interposed between the kidney and the structure to which it should adhere, which may occur either at the time the wound is closed or shortly after, the stability of the attached kidney is greatly lessened. This may be obviated by employing a gauze drain packed around and under the lower pole. An additional advantage of this gauze drain is that it lessens the strain on the retention sutures and prevents the accumulation of blood and serum about the kidney after the operation.

8. Delaying the removal of the gauze drain too long after operation, which would permit accumulation of the discharge back of the gauze.

9. Excessive vomiting or coughing shortly after operation.

10. Neglect to adjust proper support for lax abdominal walls after operation when the patient gets out of bed, or to correct by remedial measures after operation, digestive derangement and other conditions caused by the collapse.

11. Attachment of the kidney too low down in an abnormal position whereby it would be constricted and irritated by the pressure of the clothing at the waist or by the corset.

F. B. T.

The Present Status of Stomach Surgery.

A. J. Ochsner (*Interstate Medical Journal*, November, '03), maintains that stom-

ach surgery merits permanent standing in the treatment of well-recognized conditions, in fact that most diseases of the stomach which cannot be relieved by the means employed by the practitioner of internal medicine, in which hygiene and diet are of the greatest importance, must ultimately be treated surgically. In most of these cases there is faulty stomach drainage, due to a spasmodic contraction of the pylorus from the presence of an ulcer, or to the permanent narrowing of this passage from the cicatrix or other conditions secondary to ulcer, such as a pouch-like deformity of the pyloric end, an hour-glass stomach or pyloric carcinoma. Diagnostic difficulties arise from conditions entirely outside the stomach, producing symptoms referred to the stomach. Gall-stones, appendicitis, intestinal or omental adhesions, even neurasthenia, may produce symptoms rendering positive diagnosis difficult if not impossible.

To the chronic cases referred to should be added acute ulcers of the stomach not yielding to the usual medicinal treatment, all of which can be relieved by making a gastro-enterostomy between the lowest portion of the stomach and the jejunum large enough to afford permanent drainage of the organ.

The Murphy button is preferred in excision of the pylorus, but not in other gastro-enterostomies, because of liability of the opening to contract.

Of 71 gastro-enterostomies performed by the writer, 34 have been with the Murphy button and 33 with the McGraw ligature, which he has found exceedingly satisfactory.

F. B. T.

OPHTHALMOLOGY.

Idiopathic Myositis Involving the Extra-Ocular Muscles.

J. E. Gleason, A. B., M. D. (*The Ophthalmic Record*, October, 1903), reports

in detail an example of this rare and extremely interesting condition. Inflammation of muscular tissue not the result of strain, traumatism or extension from surrounding tissues is not a common occurrence in any situation in the body and but few cases of such a pathologic condition involving the extra-ocular muscles are on record. Its rarity lends to this clinical report a great deal of interest.

The patient had neither syphilis, gonorrhœa, vicious habits, bad hygienic surroundings nor anything in his ancestry to account for the occurrence of the lesions; furthermore, there was no lesion in surrounding anatomic fields which could have extended into and secondarily affected the muscular tissue.

The only departure from the normal in this clinical history of the individual was that he had had occasional attacks of rheumatism which might possibly have been an etiologic factor in the production of the disease.

The author also very properly considers the question from the possible standpoint of some form of infection which may also have been accountable for the so-called rheumatic manifestations.

A detailed clinical history is given, first of one eye in which the superior rectus was first involved and the eye lost in spite of vigorous and well directed treatment.

The final loss of the eye was brought about by corneal infection from exposure and consequent panophthalmitis. Microscopic examination of the affected muscles showed it to be about eight times its normal size; a typical microscopic picture of intestinal myositis with resulting parenchymatous changes was shown in the slide.

Three months later the patient returned with the history of having recently suffered an attack of rheumatism and showing symptoms of similar trouble in the remaining eye.

Again in spite of treatment there was a repetition of the clinical experience with the first eye and this eye was also enucleated for panophthalmitis.

Both the extra-ocular muscles were involved in this eye.

Microscopic examination showed the same condition as in the first eye. A microscopic examination of the eyeball showed it to be affected secondarily to the involvement of the extra-ocular muscles.

The author gives a resumé of the literature bearing on myositis in which the opinion is advanced that these cases are due probably to auto-intoxication or auto-infection.

D. M. C.

Electro-Cautery Treatment of Corneal Wounds and Ulcers.

John A. Donovan, M. D. (*The American Journal of Ophthalmology*, October, 1903), states that formerly he has been in the habit of treating corneal ulcers and wounds in the usual way of securing as thorough asepsis as possible and using such antiseptics as iodoform, nosophen, herophen and resorting to the electro-cautery in desperate cases and those which did not finally respond to the ordinary routine treatment.

Three years ago it occurred to him that if the electro-cautery was the thing in otherwise hopeless cases, why not employ it in the beginning in all cases of corneal ulcer and wounds of enough severity to demand any treatment.

The method is to touch the edges of the affected area with the electro-cautery, point heated to a dull red heat or in some cases a black heat of enough intensity to ignite cotton when touched.

Several cases are cited in which the method has been employed and the results have been excellent, especially as to rapidity of healing and thinness of resulting nebula.

No bad results have been noticed, even when the cornea has been perforated.

D. M. C.

Anophthalmos.

Lawrence R. Ryan, M. S., M. D. (*The Journal of The American Medical Association*, October 31, 1903), reports a very interesting case of total absence of both eyeballs at birth. The author draws the distinction between anophthalmos and pseudoanophthalmos or microsthalmos but considers his case undoubtedly one of entire absence of ocular development.

The force of the report, however, is somewhat weakened by the fact that although the child died at 3 years no post-mortem examination was permitted.

The author goes into the questions of consanguinity and maternal impression as possible causes for defective development.

This child's parents were cousins. No maternal impressions could be traced.

The child was otherwise decidedly deformed and the line of the arrested development could be pretty definitely placed before the eighth week of gestation.

The case is an interesting and rare one, therefore worthy of report.

D. M. C.

LARYNGOLOGY, OTOTOLOGY AND RHINOLOGY

The Arch of the Palate.

Henry L. Swain, M. D., of New Haven, Conn. (*Laryngoscope*, October, 1903), summarizes the findings of Grosheintz in 1898, as follows:

"A high arch is usually combined with a small development of the upper part of the face. Small nasal and orbital cavities are associated as a rule with high arched palates. The highly arched and narrow palate usually depends upon a congenital racial peculiarity of the skull, and not upon the later extra-uterine influence of nasal stenosis."

Somewhat in contradiction is the sum-

mary of Dr. Alkans, whose investigations are quoted by Dr. Swain: "First, the hard palate of the new-born child is characterized by its shortness. With increasing age, the height and breadth increase but slowly, while the length becomes proportionately greater. Second, in people afflicted with adenoids we find on the average a high, long and narrow palate, i. e., a form which does not represent the normal. Third, the shape of the hard palate has no connection with the shape of the skull. Fourth, anomalies in the position of the teeth are of frequent occurrence in those afflicted with deformities of the palate, or the upper jaw, and may be looked upon as due to the latter."

The author believes with Dr. Alkans that posterior nasal stenoses due to adenoids are responsible for the high arched palate and deformed teeth, on the theory of disuse of the nasal organ, which produces arrest of the downward growth of the hard palate, mainly through the absence of air-currents, which are supposed to excite normal functional activity. The necessity of mouth-breathing causes an unequal air-pressure, i. e., the positive against the palate, pressing upward, the negative in the nose and the maxillary sinus, hence the retardation of the normal downward growth of the maxillary and palate bones. This condition of arrested development compels the septum to adapt itself, frequently becoming deviated. The alveolar process suffers from malnutrition, secondary to mouth-breathing, the eruption of the teeth is irregular, and failure of mutual adaptation is the result. Premature loss of the temporary teeth in both the upper and the lower maxillary bones may also be responsible for irregular eruption of the permanent teeth. Nasal stenosis and early loss of the deciduous teeth, in combination, are the two strongest factors in the production of deformities of the face and improper alignment of the permanent teeth.

From the author's point of view, the following conclusions are warranted:

First, that it is possible for deforming processes which artificially change the shape of the skull to produce an alteration in the form and shape of the hard palate.

Second, that under the above conditions, the septum conforms itself to its surroundings.

Third, that lack of proper aëration of the nose and the maxillary sinuses retard their development and hence that of the whole superior maxillary bone.

Fourth, that the conservation of the temporary teeth help to produce a normal curve of the hard palate and normal alveolar process and regular arrangement of the permanent teeth.

H. J. H.

Argyrol in the Local Treatment of Diseases of the Nose, Ear and Throat.

E. B. Gleason, M. D. (*Medical Bulletin*, May 1, 1903), makes some report of his experiences along this line. Argyrol is the latest silver salt of organic compound, soluble in water of somewhat gummy consistency, causing it to adhere tenaciously to the mucous membrane. It may be applied in a 50 per cent. solution in chronic otorrhœa and in one case in which it was so used for several weeks, it produced cessation of discharge. A 20 per cent. solution applied in cases of atrophic rhinitis and ozoëma gave satisfactory results. In naso-pharyngitis, follicular tonsillitis, as well as in inflammatory condition of the larynx, its beneficial effects are rapid and effective.

H. J. H.

That the dental as well as the medical profession is desirous of reciprocity between different states of the Union is evidenced by the following resolution, unanimously adopted in August at the Asheville, N. C., meeting of the National Association of Dental Examiners:

"Resolved, That an interchange of license to practice dentistry be, and is hereby recommended to be, granted by the various State Boards, on the following specific conditions:

"Any dentist who has been in legal practice for five years or more, and is a reputable dentist of good moral character, and who is desirous of making a change of residence into another State, may apply to the Examining Board of the State in which he resides for a new certificate, which shall attest to his moral character and professional attainments, and said certificate, if granted, shall be deposited with the Examining Board of the State in which he proposes to reside, and the said Board, in exchange therefor, may grant him a license to practice dentistry."

There is a proposal to extend the work of the State Board of Health of New York to include a system of water supply and sewage disposal inspection. This plan has much to recommend it, especially a feature which looks to the rigid inspection of the sanitary features of the rural health and pleasure resorts in the state. It has been demonstrated that numbers of the cases of typhoid fever in the fall are due to the infection of patients at summer resorts, and this is a matter that cannot be looked after too carefully.

As a result of the recent legislation against improper advertising, the Michigan Board of Registration in Medicine has already taken steps against a number of offenders among the profession in the state.

At a recent meeting of the Eclectic Medical Society in Chicago the members refused to entertain an offer from the Chicago Medical Society to accept all physicians as members who did not advertise their particular school.

BOOK REVIEWS

Roger on Infectious Diseases. Their Etiology, Diagnosis and Treatment. By G. H. Roger, M. D., Professor Extraordinary in the Faculty of Medicine of Paris, Etc., Translated by M. S. Gabriel, M. D., New York. In one Octavo Volume, of 864 Pages, with 43 Illustrations. Cloth, \$5.75, Net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1903.

When Dr. Roger planned this work, he laid out his plans for a comprehensive, and indeed, practically exhaustive, resumé of the subject suggested in the title. These plans he has carried out, with the result that his work is a splendid specimen of what wide knowledge, practical experience in abundance and a facile pen can effect, in judicious combination. By a nice perception of the close relation that should always exist between clinical observations and laboratory findings, he has kept the two subjects in the most intimate connection throughout the text. He first takes up the nature of the pathogenic agents, then makes inquiry concerning their distribution in nature, and finally the conditions under which they attack man, with the varying modes of invasion. The battle waged between the human economy and the invaders is fully considered, and there is much space devoted to considerations of diagnosis and prognosis, when the disease under consideration is once fixed. More than 200 pages are devoted to prophylactic and curative therapeutics, and we may be sure that what Roger has to say on this subject is eminently authoritative.

Owing to the extraordinary opportunities for the study of infectious diseases which Dr. Roger's position gave him, he is well fitted to undertake the work of writing such a book. All the patients in Paris, suffering from infectious diseases,

are received in the hospitals of which he is in charge, and he has personally attended more than 10,000 cases in five years. He has undertaken to bring clinical and experimental observations into close, and perhaps more friendly relation, and in our judgment has done much toward securing a desirable end. He has been fortunate in his translator. Dr. Gabriel has furnished us with an easy-reading text, couched in excellent English, and bearing the stamp of authority and experience. For those who are especially interested in the careful study of the infectious diseases, this book of Roger's should furnish excellent material. Its price is within reason for a book of its calibre.

Whitman's Orthopedic Surgery. New (2d) Edition. A Treatise on Orthopedic Surgery. By Royal Whitman, M. D., Instructor in Orthopedic Surgery in the College of Physicians and Surgeons (Columbia University), New York; Associate Surgeon to the Hospital of St. John's Guild; Chief of the Orthopedic Department of the Vanderbilt Clinic, Etc. Thoroughly Revised, and Much Enlarged. In one Octavo Volume of 820 Pages, with 507 Engravings, mostly Original. Cloth, \$5.50, Net. Lea Brothers & Co., Publishers, Philadelphia and New York.

The importance of the general subject of orthopedic surgery was clearly understood by Dr. Whitman when he undertook the first edition of the work under consideration, only a comparatively short time ago. The issuance of the first edition was the signal for the approval of the profession, and the edition was exhausted within a short time after its issue. By the taking of new subjects for consideration, somewhat more extended descriptions of others, and the addition of about sixty engravings, the material

scope of the book has been considerably enlarged, but on the whole the work remains as it did in the first successful edition.

The work is primarily intended for the use of students and practitioners, but the including of statistical and other data makes it one of value to experienced workers in the special field of this important branch of surgical science. Dr. Whitman has aimed at a thoroughly modern form of the book, and with this end in view has made a most thorough and careful revision of the text of the first edition, the present work containing practically all that has been made known lately, including, of course, the Lorenz operations. Profuse illustrations, most of them reproduced from original and valuable photographs, are included in the pages, and form an almost indispensable adjunct to the text. A number of illustrations of the most modern deformity apparatus form an essential portion of this feature of the work. Like all the Lea books, it is published with scrupulous attention to the details that make for attractiveness; and the reasonable price of the first edition has been retained.

Egbert's Hygiene. New (3d) Edition. A Manual of Hygiene and Sanitation. By Seneca Egbert, M. D., Professor of Hygiene and Sanitation in the Medico-Chirurgical College of Philadelphia. Enlarged and Thoroughly Revised, in one 12mo. Volume of 467 Pages, with 86 Illustrations. Cloth, \$2.25, Net. Lea Brothers & Co., Publishers, Philadelphia and New York.

In the past five years three editions of this book have been necessary, a fact which speaks well for the popularity it has already enjoyed. The present form of the work is nearly a third larger than its predecessors, and contains an enormous amount of authentic information. The

subject is an important one, and Dr. Egbert is thoroughly well equipped to handle it, as his previous work has already abundantly shown. The third edition is thoroughly modern in every sense of the word, and shows the result of careful condensation on every page.

It is likely to have a demand at the hands of others than members of the profession, and indeed it is well suited to the needs of the layman who cares to "read up" on a subject of such wide interest. For the physicians, there is absolute authenticity and completeness; for the layman there is a vast deal of interesting subject-matter; and for both, there is a handsomely published and really valuable book at a low price. The illustrations have been chosen with much care and show the most modern ideas in sterilization, heating and ventilation and other subjects of importance. We predict a ready and large sale for the book in its new shape.

Compend of Gynecology. By William H. Wells, M. D., Chief of the Gynecological Staff of the Mt. Sinai Hospital, Philadelphia, Etc., Etc., Etc. Third Edition, Revised and Enlarged, with 145 Illustrations. Pages, 265. Price, Cloth, \$8.00, Net. Philadelphia, P. Blakiston's Son & Co., Publishers, 1012 Walnut St., 1903.

The fact that this compend is now in its third edition may be taken as strong evidence of the readiness with which it has been received by students and practitioners all over the country. The present form of the work has been thoroughly revised, and brought down to date, and several new operations have been described. It has been the aim of the author to give the technique that seems to be most generally in favor among the recognized authorities in describing the operations, and while it is necessarily impossible in the limits laid out to include

everything that bears on such a wide subject as gynecology, Dr. Wells has put all the essentials into his small but comprehensive book. The new form of the work includes a section on the general therapeutics of gynecology and the illustrations are unusually profuse and well adapted to their purpose. We can heartily congratulate the publishers on the success which this edition is likely to receive at the hands of the profession. It is especially adapted to the needs of the student, and the gynecologist will find profitable reading in its pages. Dr. Wells has had an exceptional opportunity for study and observation in his clinical practice and he is well known as a close observer.

The Physician's Visiting List (Lindsay & Blakiston) for 1904. Fifty-Third Year of its Publication. Philadelphia: P. Blakiston's Son & Co. (Successors to Lindsay & Blakiston), 1012 Walnut Street. Sold by all Booksellers and Druggists.

This book needs no recommendation from us, and we mention it simply to recall to the minds of its old friends the fact that it is prepared for them for another twelve months. For more than half a century it has been in wide use, and its users could scarcely get along without it. It is as complete, compact and simple as anything of the kind on the market, and is gotten up attractively. Accounts may be opened at any time, and the name of the patient is the key to all necessary information about the case. It is handsomely bound in black leather, with a pencil, pockets, etc., and retails for the low sum of \$1.00.

Clinical Treatises on the Pathology and Therapy of Disorders of Metabolism and Nutrition. By Prof. Dr. Carl von Noorden, Physician in Chief to the City Hospital, Frankfurt a. M. Authorized American Edition Translated under the

direction of Boardman Reed, M. D. Part IV. The Acid Autointoxications. By Prof. Dr. Carl von Noorden and Dr. Mohr. Price, Cloth, \$.50. New York, E. B. Treat & Company, Publishers, 1903.

The clinician should be greatly interested in this series of studies into the derangements of metabolism which result in an over-production of acid. The field is little explored, in spite of the importance which is now almost universally attached to the doctrine of autointoxication. Dr. von Noorden's work bears all the marks of faithful and painstaking study and experiment, and all physicians who are keeping an intelligent watch on the digestion, assimilation and excretion of their patients will find the time well spent which is devoted to reading the present monograph. Dr. A. C. Croftan, who has translated the first three books in the series, has done the same work in the little volume under discussion, and has done it very well indeed. Other monographs on the same general topic are announced by the publishers.

The Concise Obstetric Record. Designed for Systematic Recording of Obstetric Work. Price, \$2.00. Copyright Applied For. Published by Systematic Record Publishing Co., Detroit, Mich.

The value of faithfully recorded observations was never more clearly in the professional eye than at the present time of almost universal research work. The physician who does much obstetric work may well take a leaf from the book of the laboratory worker in keeping a faithful record of his obstetrical cases, covering such data as will prove of value in treating other cases. This book is published for the purpose of making such work as easy as possible, and it appears to have been designed with care for this object. There are a number of pages setting forth a general record of each case treated,

with notes on the exact condition of each important thing in the case; also a space for daily record of temperature, pulse, stools, lochia, etc., and a wide space for general treatment notes.

A number of pages for a general summary is furnished at the back of the book, and arrangements are made for an index, although the publisher has unfortunately neglected to number the pages, making the work of indexing somewhat difficult. The book is sufficiently large to last the average general practitioner a number of years.

Lea's Series of Medical Epitomes. Hale's Epitome of Anatomy. A Manual for Students and Physicians. By Henry E. Hale, A. M., M. D., Assistant Demonstrator of Anatomy College of Physicians and Surgeons (Columbia University) New York. 12mo., 384 Pages, 71 Illustrations. Cloth, \$1.00, Net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1903.

Every practitioner recognizes the value of a clear knowledge of anatomy, and every student knows by hard experience how difficult it is to get hold of some portions of the subject. Gray's Anatomy will give the conscientious reader all the knowledge he is ever likely to need on the subject, but its size and its price alike are somewhat large for common use. If a student wishes to make use of all his time in reading medicine, he will find the little volume under discussion "about his size." It contains the essentials of the subject, and into these essentials the student may weave the details from his Gray, or from other text-books. A complete outline of human anatomy is given here, and a series of quiz questions at the end of each division of the text serves to impress the fundamentals.

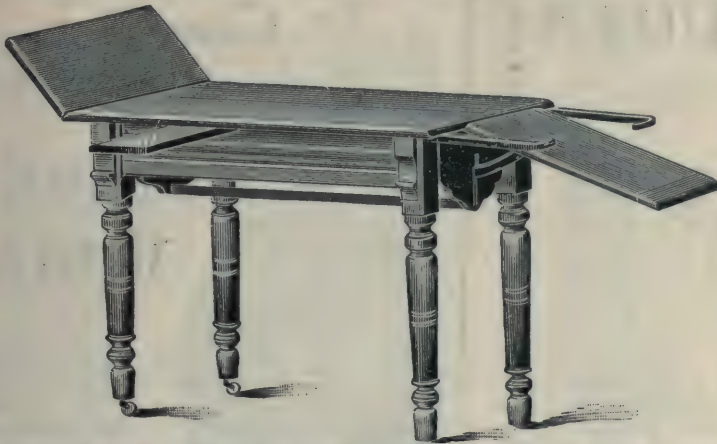
This is the era of concentration, and these epitomes are doing their part to

carry out a very general plan. They place reliable information in an extremely convenient form, and they can be published at a price which makes no very serious demands upon the purse of the student. They are handsomely published and well illustrated and eventually form a convenient auxiliary library for use in brushing up a subject that comes up for discussion. We have had occasion many times to comment favorably on the character of these books as a whole, and the present volume is in every way worthy of a place in the series.

The Medical News Visiting List for 1904. Pocket-sized, Wallet-shaped Book. Eighteenth Year of Issue. In Four Styles, to Meet the Requirements of Every Practitioner. Weekly, dated, for 30 Patients; Monthly, undated, for 120 Patients per Month; Perpetual, undated, for 30 Patients weekly per Year; 60-Patients, undated, for 60 Patients weekly per Year. Bound in Flexible Leather, with Flap and Pocket, Pencil and Eraser, and Calendar for two Years, \$1.25. Thumb-letter Index, 25 cents extra. By mail, postpaid to any address. Lea Brothers & Co., Publishers, Philadelphia and New York.

An old friend. The text portion has been revised and brought down to date. A number of useful departments are included this year, and all the well known former features retained. As "handy as a pocket in a shirt."

Northwestern University, Chicago, was damaged to the extent of \$35,000 by fire on November 20. The building at the corner of Dearborn and Lake streets caught fire from some unknown cause and before the flames could be extinguished the damage mentioned had been done. Classes are to be abandoned until necessary repairs are made.



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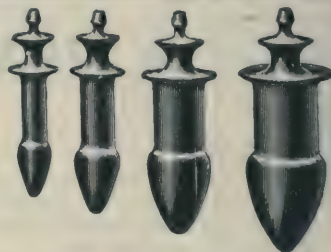
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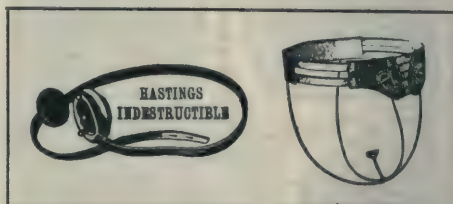
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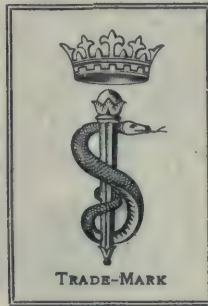
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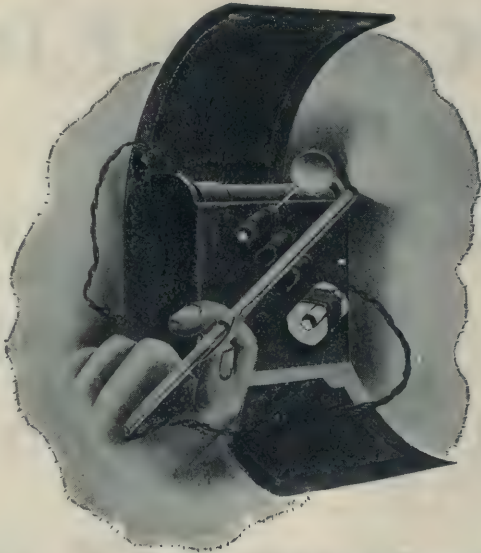
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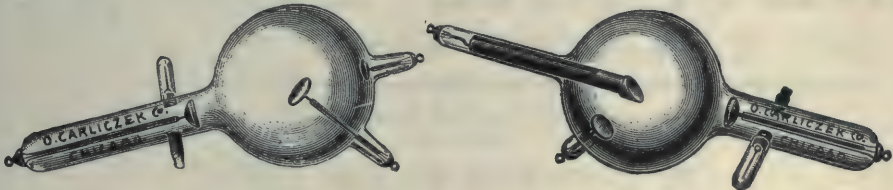
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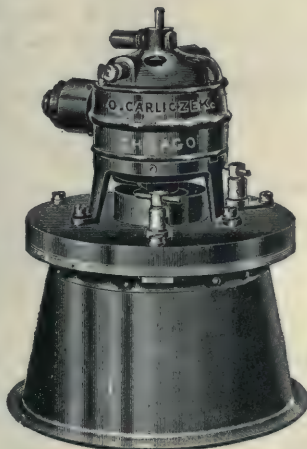
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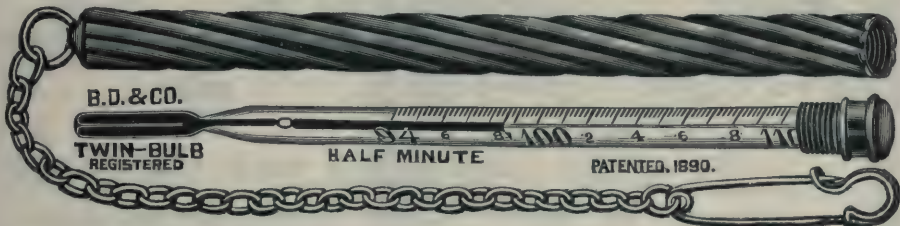
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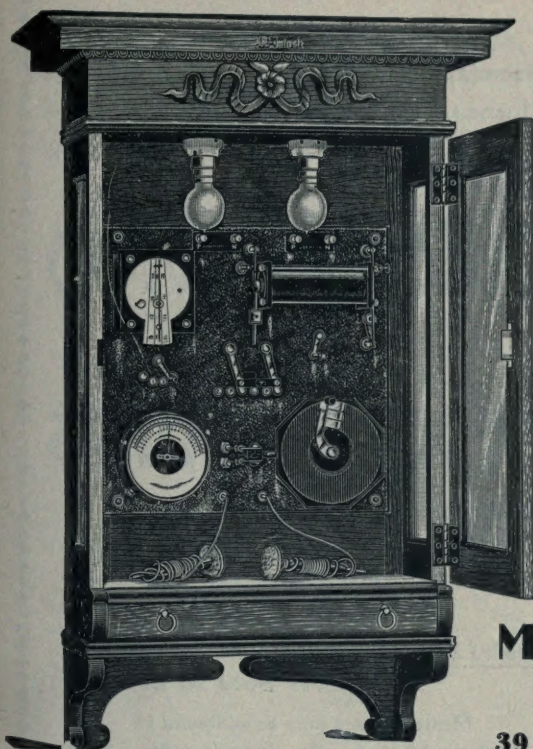
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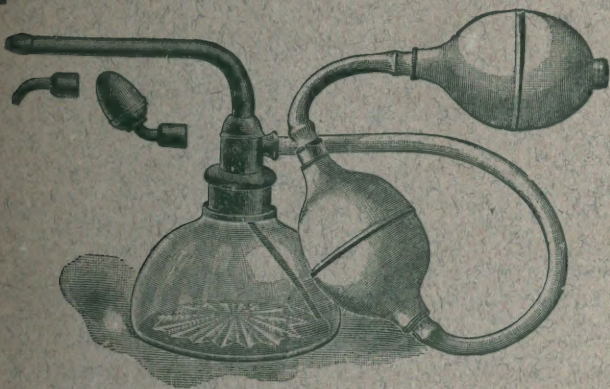
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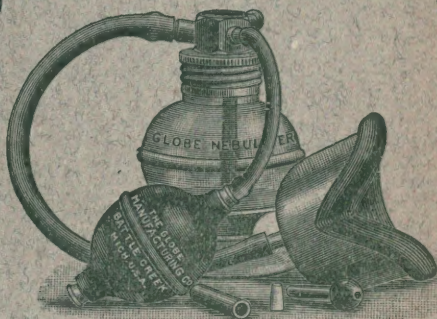
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Camphor Gum, 1 drachm.
Oil Tar, 40 min.
Formula No. 1, q. s. ad 4 oz.
For Laryngeal and Pulmonary Tuberculosis.
Four oz., 40 cents.
One pt., \$1.50.

FORMULA NO. 9.

Cocaine Alkaloid, 8 grs.
Oil Cassia, 30 min.
Menthol, Crystals, 1 drachm.
Camphor Gum, 1 drachm.
Alboline, q. s., 4 oz.
For acute Congestion and Inflammation of
Nose, Throat and Middle Ear. The oil base
prolongs the effect of the cocaine.
Four oz., 50 cents.
One pint, \$1.80.

ALKA ANTISEPTOL.

1 pt., 50 cents.

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LISTERINE

A Non-toxic, Non-irritant, Non-escharotic Antiseptic.

ABSOLUTELY SAFE, AGREEABLE AND CONVENIENT.

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For diseases of the uric acid diathesis:

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A remedy of acknowledged value in the treatment of all diseases of the urinary system and of especial utility in the train of evil effects arising from a uric acid diathesis.

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